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MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

BALTIMORE CITY HOSPITALS ISSUE

Maryland

STATE MEDICAL JOURNAL

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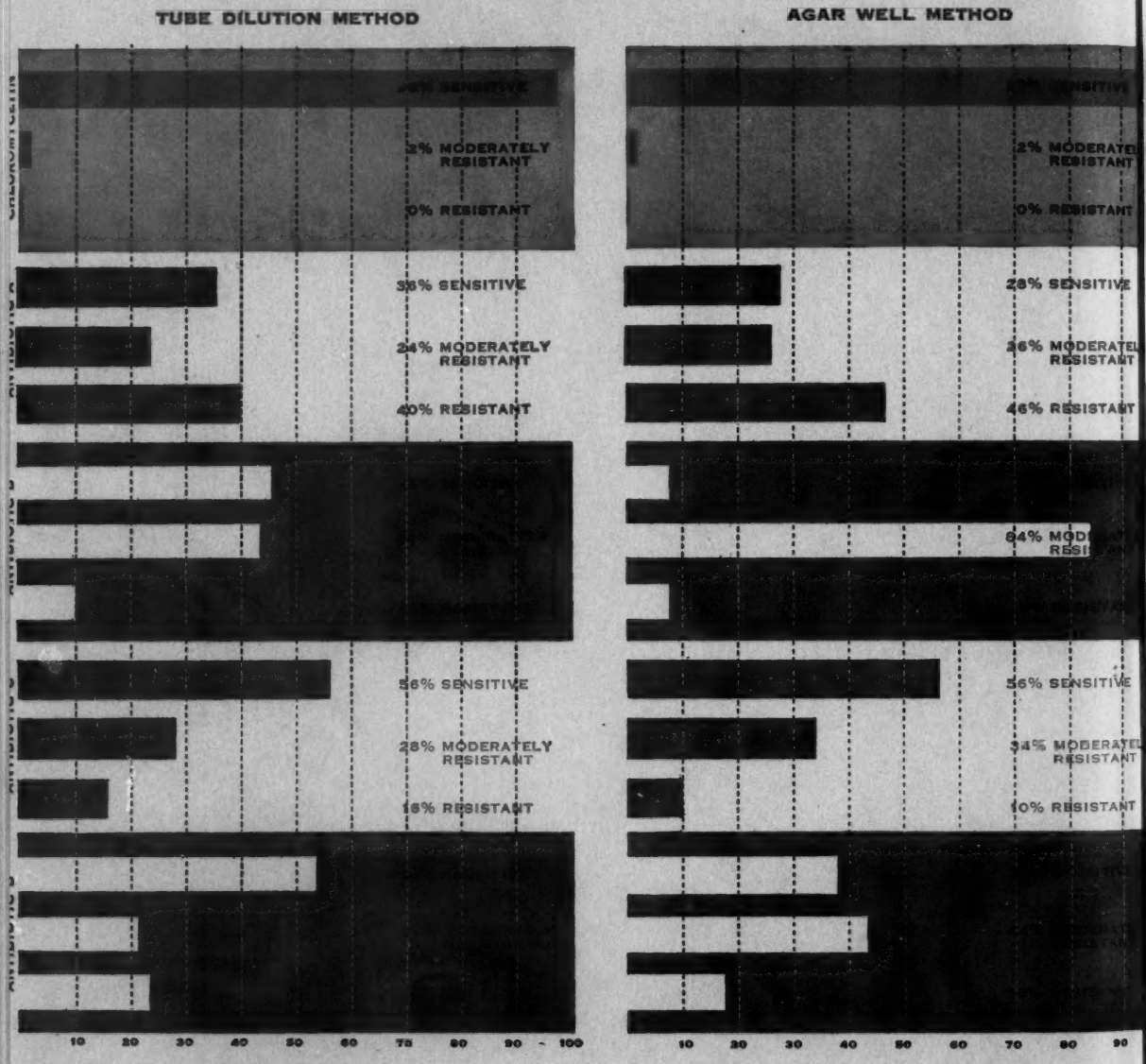

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Medical and Chirurgical Faculty of the State of Maryland

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VOLUME 4 | *December, 1955* | NUMBER 12

CONTENTS

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BALTIMORE CITY HOSPITALS ISSUE*

Dr. Arthur M. Shipley
Chief Surgeon, 1911–1939

Dr. Thomas R. Boggs
Chief of Medicine, 1911–1938

This issue is dedicated to that large group of Physicians who helped lay the foundations for the present Baltimore City Hospitals—of whom the above men were outstanding.

* The following material is presented for the purpose of acquainting our readers with the remarkable progress of Baltimore City Hospitals. The articles are primarily departmental and historical in character.
—THE EDITOR.

Special Articles

BALTIMORE CITY HOSPITALS

PARKER J. McMILLIN*

Front View of Bay View Asylum, built 1866.

As the story of Baltimore City Hospitals is presented, it is quite appropriate first to give attention to the question "What is a hospital." Certainly, it is more than a modern building with modern equipment. Although today these are necessary parts thereof, the hospital is a health team—doctors, nurses, technicians, social workers, secretaries, engineers, dietitians, volunteers, carpenters, and housekeepers; it is a restaurant providing food for special needs; a laundry; a power plant; a pharmacy; a laboratory for x-ray, pathological and other diagnostic services. It is also an educational institution training doctors, nurses, and other personnel. It is a work-shop for physicians. It may be a center for medical research. It is a center for community health. It is helping to close the gap between preventive and curative medicine.

* Superintendent, Baltimore City Hospitals.

It is all of these things—and many others too. Twenty-four hours a day—365 days a year, year in and year out, its doors are never closed. While hospital business is "big business," it is "big business-plus," and this "plus" is what distinguishes it from commerce.

(A) With a few exceptions, it is non profit.
(B) Its "product" is human life.
(C) Its principals are professional people.
(D) Its services are not infrequently rendered at a charge below the total cost.

The end product is community health, not financial profit. Hospital care is an essential community service which varies from institution to institution depending upon the amount of medical knowledge applied and the assignment of each hospital in meeting the community's health needs. The "house of mercy" may be 1,000 beds in a metropolitan hospital or twenty-five beds in an isolated mountain community.

In language somewhat like that just used, the American Hospital Association gives the answer to "what is a hospital." Baltimore City Hospitals takes its place as one of approximately 7,000 such institutions now in the United States. Its origin and development is closely interwoven with the early history of the area now known as Baltimore.

The institution in which the modern hospital had its origin is known to have been in existence prior to 400 B.C. In those early times, the purpose of the institution was quite different. It was intended primarily to remove the afflicted and unsightly from the public gaze. The history of these institutions as they developed down through the ages into the modern hospital of today makes fascinating reading. That development was not as rapid as one might think. For example, as these institutions made their first appearance in North America they were primarily alms-houses, pest houses, and quarantine stations. The first of these, the hospital of Immaculate Conception, in Mexico City, was built in 1524. It still exists today as the hospital of Jesus of Nazareth.

The first such institution to be established in the territory which later became the United States of America was in what is now New York City. In 1658, a hospital was erected for the care of sick soldiers who previous to that date had been billeted on private families. It also served the negro slaves of the Dutch West India Company. New York City, then called New Amsterdam, had a population of about 1,000 of whom a considerable number were negro slaves.

As Boston, New York, Philadelphia, Baltimore, Charleston, and other seaport towns grew in the 17th century, it became more necessary to provide isolated refuge for shipboard victims of contagious diseases. These pest-houses and quarantine stations located outside the cities, or on islands, were not used by the city's inhabitants. It was in this environment and under these conditions that the alms-house came into being. While these always had "beds for the sick and foundlings" they, of course, did not fill the role of a hospital as we think of it today. In 1713, one of these alms-houses was established in Philadelphia and today it is the Philadelphia General Hospital. In 1736, one was established in New York—which is now Bellevue Hospital; and one was established in New Orleans—which now is Charity Hospital. In 1776, the year in which our nation was born, one of these alms-houses was established in the area now known as Baltimore. This was the beginning of Baltimore City Hospitals.

It is interesting to note that before alms-houses were established in the state of Maryland, the county courts had levied tobacco from year to year for relief of the sick and infirmed poor. The Baltimore County Alms House was authorized and erected for care of the sick and infirmed poor, thus replacing the policy of levying tobacco for such use. Laws of 1773 authorized buying ground for an Alms House. An elevated and beautiful site of the future Alms House was purchased for 350 pounds of tobacco. It was situated northwest of Baltimore town, contained approximately twenty acres, was nearly in the form of a square, and was bounded by Eutaw, Biddle, Linden Avenue, and Madison Streets. Those acquainted in Baltimore will recognize this area as that which is now occupied by the old Richmond market. The necessary buildings were erected, the grounds properly laid out and planted, excellent water procured from two wells about seventy feet deep, and the plant was placed in service early in 1776. History tells of a fire breaking out in September of 1776 which partially destroyed the main building and east wing before it was brought under control by the engine from Baltimore Town. The main building was immediately rebuilt and the wing was replaced some years later. This Alms House was supported jointly by the City of Baltimore and by the County of Baltimore. There are no records, however, which indicate the number of beds available for care of the sick, or the overall census of the institution during its operation.

The Alms House continued to be operated in this location for a period of forty-seven years, or until a new road was opened as an extension of Howard Street. Since this new road extended through the property, it was decided to move to a new location, and that again the location would be well outside of the city limits, thus getting away from the noise and confusion brought about by heavy city traffic.

In 1819, the City and County of Baltimore jointly, for the sum of $44,000, purchased from the Mechanics Bank of Baltimore, "Calverton" formerly the County seat of Dennis A. Smith, with its splendid mansion, to which the trustees added two wings—130 by forty feet each, and other necessary out buildings. All of these formed the large and elegant Alms House, which in point of extent, convenience, and beauty of location, was not surpassed in its day by any similar establishment in the United States. History so describes this second Alms-House which ultimately became Baltimore City Hospitals. This new location contained 306 acres and was that area which today is a closely built up section of the City of Baltimore, bounded by Pulaski and Poplar Grove Streets on its east and west sides; and extending from Lexington Avenue on the South to Presstman Street on the north. All of the buildings were completed and the new Alms House in service late in 1822, when 533 paupers of the City and County were removed from the old Alms House to the new one at Calverton. In 1823 first new admissions were made to the new Alms House.

There were difficult times and problems in those days as now. For example, cholera broke out in the new Alms House in 1832, and of the approximately 500 patients, 125 died of this dread disease. Again, during the summer of 1849 cholera prevailed to an alarming extent. During this episode, the first death from the epidemic occurred on the 11th of July and the last on the 4th of August. During this short period of time, it is recorded that there were 158 cases and ninety-four deaths.

It is interesting to note that as was the case in the first location, the Alms House continued to operate in this new location just over forty years. To be exact, it remained here for forty-three years, or until 1866. In 1853, the city of Baltimore became separated from Baltimore County. In 1862, a Baltimore City Ordinance, #40, authorized buying a site from the Canton Company for a Baltimore City Alms House to be called "Baltimore Bay View Asylum." Again, location of the site was outside of the city, far to the east, where there would be relief from the chaos of heavy traffic.

In 1866, the paupers of the city were transferred from Calverton to this new Bay View Asylum, which was now being operated as strictly a city project. The site for this new institution—made up of forty-six acres—was purchased from The Canton Company at a cost of $150 per acre. Later on, the size of the site was increased until finally it was made up of 240 acres. As described in the history, the building was exceedingly imposing in appearance, and located upon a hill high enough to render it conspicuous for miles around. Over $500,000 had been expended on the premises and all known appliances were provided to make the asylum and its grounds equal to the best in the world. The wings and center building gave an aggregate front of 714 feet, while it was three stories and 184 feet in height. The base was estimated to be one hundred feet above tide water. More than seven million bricks were used in work of erection.

If history was complete and in adequate detail there no doubt would be many interesting items recorded concerning this old institution. There is one incident which is interesting but which comes through another channel than history. Certain portions of this old Bay View Asylum have recently been used in construction of a new and modern infirmary division of Baltimore City Hospitals. On February 8, 1953, as a portion of an old wall was being removed a workman found a pair of boots which had obviously been

buried in the wall at time of original construction. Inside one of these boots was found a note reading "buried in October 1868." The note was signed, but it was not possible to make out the first name. The last name of the signor was "Cassell." Folks active in organized labor report that the name Cassell can be traced to the founding of the bricklayers union in 1866, he being one of the five bricklayers who founded that Union.

Management of this Baltimore Bay View Asylum was placed in the hands of a Board of five citizens called Trustees of the Poor and who were appointed by the Mayor and City Council. This management continued until 1900, when a new City Charter created the Board of Supervisors of City Charities—made up of nine members. The Charter required that in addition to management of the Bay View Asylum, the Board of Supervisors of City Charities would assume responsibility for administering all of the charity work of the City. Members of this Board were appointed by the Mayor and served without salary.

Although again this institution was primarily an Alms House from its inception, there is record of available facilities for "care of the sick." Through the years, demand for these facilities became greater and greater. The type of patients admitted gradually changed and the emphasis of care changed from that of the alms house to that of the hospital, namely: "care of the sick." From time to time new hospital divisions were added until now there is a modern Baltimore City Hospitals carrying as its major function "care of the sick."

At the Fall Election in 1934, a City Charter amendment was adopted by the community. This Charter amendment abolished the Board of Supervisors of City Charities and created the Department of Public Welfare. The hospital remained a part of this new Department of Welfare. By act of the Board of Supervisors of City Charities back in 1925, name of the institution had been changed from Bay View Asylum to Baltimore City Hospitals. At the time the name was changed, records indicate the Board had determined to change this institution into a complete new and modern hospital. When the new Department of Welfare came into existence, steps had already been taken to convert the institution into a modern hospital. The new Nurses Home had been completed; facilities had been made available for acute surgical services and obstetrical services; a new power house had been completed; the new general hospital building was under construction and well along toward completion. These facts would indicate that there was foresight and recognition of need in the old Board of Supervisors of City Charities. The initiative which brought about the decision of the old Board and these early steps toward revamping the hospital was taken by Doctor George Walker, now deceased. He was ably supported by Mr. William L. Galvin.

Not only did this era of 1934–35 bring about the initial steps toward new and modern physical facilities, but there was thinking in the direction of a completely new professional organization—a much more intimate relationship with the two local medical schools, and development of a modern, complete teaching program at both the under-graduate and post-graduate levels. In this thinking was the plan to place competent physicians in charge of the various services on a full-time basis. The first of these was the Chief of Pathology. The Chief of Radiology soon followed and a little later on, the Chief of Pediatrics. How consistently this thinking has been followed through the years will be realized when it is pointed out that Pathology, Radiology, Pediatrics, Medicine, Tuberculosis, Dentistry and Anesthesia are all now headed by a chief on a full-time basis. In addition, on all of these services, with the exception of one, additional men are serving on a full time basis as associate and assistant chiefs. Currently, candidates for the position of Chief and Assistant Chief of the Obstetrical Service are being considered and this service will be so staffed before the end of 1955.

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In 1956, the Surgical Service will be reorganized and headed by a full time Chief, with full time Assistants. With this type of professional organization carrying the responsibilities of the hospital more intimate relationships with the two medical schools are but a natural sequence. Much progress has been made toward development of a modern and dynamic teaching program at both under-graduate and post-graduate levels. All of this is conducive toward providing better professional care for patients admitted to the hospital, doing a better job of teaching in the professional field, and providing material of real value to posterity through research in the field of disease and prevention of disease. Through all of this change and progress, the primary purpose of Baltimore City Hospitals, as stated in the Charter creating the hospital, has continually been kept in mind. This statement in the Charter indicates that the hospital is for the purpose of caring for indigent residents of Baltimore. A statement of Policies and Routines governing admission of patients, printed in full as one of the articles of this series, will show how this original purpose of the hospital is being respected and adhered to. Other articles in this series are written by Chiefs of the various services and will indicate how these services have been developed and what is currently being done in the professional field.

Baltimore City Hospitals as it is now constituted is unique in that it has facilities for all types of patients, except mental diseases. There is the Infirmary Division, taking care of ambulatory older folks who would be unable to adjust in the community even though on Old Age Relief. When the new unit now under construction is completed, there will be facilities for 900 patients in this Infirmary Division. There is a large unit with capacity for about 500 patients with long time illness. There is a Tuberculosis Division carrying currently a census of 300 patients, but having unused facilities which makes possible increasing this capacity to 440 patients. There is the General Hospital Division with a capacity of about 460 patients, in which is housed all of those patients coming within the category of acute illness. In this Division, communicable diseases are cared for—the children being assigned to Pediatrics and adults being assigned to Medicine. Finally, there is the Out-Patient Department with a capacity of about 500 visits per day. Currently, the service load in this unit is averaging about 200 visits per day.

While figures and statistics are fatiguing, no history of Baltimore City Hospitals would be complete without quoting at least some financial figures. Money for operating Baltimore City Hospital comes from the general fund of the City, which in turn is raised through taxation. In the year of 1935, a total of $778,600 was disbursed while in 1955 this figure will rise to $3,585,000. Of the latter amount, approximately $350,000 will be recovered through charges for County patients and that limited number of patients who are admitted by reason of emergency and who are found either to be in position to pay for services personally, or are covered by some type of insurance. The operating costs compare favorably with those of other hospitals. Folks who are competent to judge and are in touch with Baltimore City Hospitals say that the delivered professional service is excellent, that the teaching program being carried deserves praise, and that a real contribution to posterity is being made through active research programs. Dr. Louis A. M. Krause recently spoke to a group in the Department of Public Welfare on the history of Baltimore City Hospitals. He closed his address with a paragraph which would seem to be pertinent here. That paragraph reads:

"Without a doubt, the future of City Hospitals appears quite rosy and it will become an increasingly more important institution in the social and medical fabric of Baltimore City. As to paraphrase Osler, I can picture the City Hospitals as become a place of refuge for the sick poor; a place where the best that is known is taught to a group of the best students; a place where much thought is devoted to research; a school where men are encouraged to base the art of medicine upon the science of medicine;

a fountain to which those interested in the whole subject of medicine would come for inspiration; a place with a hearty welcome to every practitioner who seeks help, and a consulting center on cases of obscurity."

To the readers of the MARYLAND STATE MEDICAL JOURNAL, Baltimore City Hospitals extends a cordial invitation to visit the hospital; either as just a visitor looking around or as one who may be seeking consultation in some situation where there may be some degree of obscurity. The members of the professional staff and the administration of the hospital will be glad to welcome you.

Baltimore City Hospitals,
Baltimore 24, Maryland

ADMITTING POLICIES AND ROUTINES

Effective as of July 1, 1955

(Revised for purposes of clarification)

This memorandum is intended as a statement of policy to govern admission of patients for care, either as In-Patients, Out-Patients, or Emergency treatment. It is further intended to outline, in a general way, routines through which request for admission, and admissions, shall be routed. Content of the memorandum is the result of studies and decisions made by the Staff Conference Committee, and the memorandum itself is to serve as a guide for all who may be concerned with admissions in any way. Any prior statement of policy contrary or inconsistent with this memorandum is hereby abolished. The memorandum has been properly approved by the Medical Advisory Board, and finally by the Advisory Board of the Department of Welfare.

The basic controlling principle of the policy governing admissions is this statement—Baltimore City Hospital is owned, maintained, and operated by the City of Baltimore for the purpose of providing professional and hospital care for indigent, or medically indigent, residents of Baltimore. Principles of eligibility are stated in the following, including income scales for Out-Patients and In-Patients. Emergency accident room treatment is considered Out-Patient service.

PRINCIPLES OF ELIGIBILITY

1. Except as indicated in the following paragraphs, patients must be residents of Baltimore City (one year without relief).
2. No charge will be made for patients having income less than shown in the proper income scale following.
3. Patients having income over the accepted minimum scale and under the maximum scale will pay for services rendered in accordance with their ability, up to the rates as are given to the Revenue Investigator from time to time.
4. Patients receiving public assistance from the Department of Welfare are eligible for dispensary care during the interim from the time they come on relief and are picked up by the Medical Care Clinic to which they are assigned. (They are always eligible for admission as In-Patients.) After assignment to Medical Care Clinics, however, they are not eligible for service in Out Patient Department of B.C.H.
5. Any individual being wholly or partially supported by a public or private agency in the City of Baltimore is eligible for admission as an In-Patient.

If the following number of persons are dependent	And, if the income is up to or below the minimum amount of this scale, he is eligible for care without charge to him. He is not eligible for care if his income is over the maximum.					
	Minimum Weekly	Maximum Weekly	Minimum Monthly	Maximum Monthly	Minimum Annually	Maximum Annually
Out-Patient Income Scale						
1	$19	$48	$83	$208	$1,000	$2,500
2	23	57	100	250	1,200	3,000
3	27	67	117	291	1,400	3,500
4	31	76	133	333	1,600	4,000
5	35	86	150	375	1,800	4,500
6	38	96	167	416	2,000	5,000
	Add $200.00 annually for each additional person over 6.					
In-Patient Income Scale						
1 person	$31	$48	$135	$208	$1,620	$2,500
2 "	42	57	185	250	2,220	3,000
3 "	48	67	210	291	2,520	3,500
4 "	55	76	240	333	2,880	4,000
5 "	61	86	265	375	3,180	4,500
6 "	67	96	290	416	3,480	5,000

In instances where head of the family is, or has been out of work for a considerable time, this circumstance should be given consideration in determining eligibility. Where time permits, or at discretion of the Screening Officer, applicants should be referred to the Revenue Investigator for decision as to eligibility.

All patients receiving care in Baltimore City Hospitals, either as In-Patients, Out-Patients, or Emergency treatment in the Accident Room should qualify as eligible under the statement of principles as above—with certain exceptions, and under certain conditions, as indicated in the following paragraphs.

1. *Tuberculosis.* Residents of the City of Baltimore having positive or suspected diagnosis of Tuberculosis, may be admitted for care and treatment without a means test and without charge. This applies in all types of Tuberculosis. This policy does not apply under any circumstances, however, where the patient is not a legal resident of Baltimore, and non-residents of Baltimore with Tuberculosis—positive or suspected—should never be admitted, except in dire emergency and patient is at our door.

2. *Communicable Diseases.* Legal residents of the City of Baltimore having positive or suspected diagnosis of some communicable disease may be admitted for care and treatment without a means test, and without charge.

Transfer of patients—even though not residents of Baltimore City—may be accepted from other hospitals in Baltimore where some communicable disease has developed after admission to that hospital. (For purposes of this paragraph, Tuberculosis is not included.) Where patient for whom transfer is requested has residence in one of the Counties of Maryland, then authority for admission should be obtained through routine as specified in Paragraph # 10 following before transfer is accepted. Otherwise, the patient may be accepted for transfer and the Revenue Investigator will follow for collection of charge for service.

3. *Foster Children.* The Children's Division of the Department of Welfare have something over 1,000 children in foster care. Most of these are assigned to Foster Homes in Baltimore, but some are assigned to homes in areas outside of the City of Baltimore. In all instances, where assigned to foster homes inside or outside of Baltimore City, the child is to be admitted when requiring In-Patient Service. Likewise, children in foster care under care of any Maryland County, but assigned to Foster Homes within Baltimore City, are to be similarly treated. For service in the Out-Patient Department, these children come under the Medical Care Clinic set up as a unit in the O.P.D. for the purpose, and the conditions of this program are to apply.

4. *School Accidents and Amateur Athletic Contests.* Children and young folks coming from accidents in school buildings, in school play yards, or during participation in amateur athletic contests, when these are located within the City limits, should be admitted and cared for as required. (Applicants coming from such areas located outside of City limits should be treated as all other applicants from County.) Ordinarily, there will be no charge for this service. Any exception will be determined by the Revenue Investigator. An exception, for example, might be when the patient has insurance protection of some kind.

5. *City Jail.* When a prisoner has completed sentence and is not ambulatory at time of discharge, and the jail has no place to send such prisoner, Baltimore City Hospitals is to accept for care and treatment, until some disposition can be worked out. The City Jail will also ask for service in instances of acute illness on the part of a prisoner. When there is any question concerning the need of hospitalization, it is wise to have the person serving sentence sent out for examination and a decision concerning admission to be based on physical examination and clinical findings.

6. *Police Cases.* All police prisoners being brought in direct by the police, or being transferred from another hospital by the police, are to be accepted for care and treatment as re

quired. These patients should be so grouped in a single area as to make possible guarding of the patients by one police officer. The reason for accepting these cases by transfer from other hospitals is to make possible the Police Department using lesser number of officers for guard duty by concentrating all prisoners in one hospital, and in one area of that hospital.

7. *Other Exceptions to the Basic Principle.* As everyone well understands, there comes to the Accident Room certain patients who, by reason of their serious condition, must have attention; sometimes including admission as in In-Patient, even though not eligible for admission under the principles stated. Under such circumstances, the patient is to be admitted and the Revenue Investigator will set up full charge, including professional service fee. This policy is set up under a memorandum approved by both the hospital and the local Medical Society, reading as follows:

FIRST: That Baltimore City Hospitals continue to use every possible precaution to prevent admission of patients to the hospital, or care to patients in the Accident or Out-Patient Department, who are in position to pay for professional services.

SECOND: That where a patient is admitted through emergency and found to be in position to pay for service, a professional service charge is to be made, this charge to be in addition to charge for hospitalization.

THIRD: That Baltimore City Hospitals, having started treatment of a patient through emergency, is responsible and should continue such treatment to completion, except:

FOURTH: That, where the patient admitted through emergency is in a position to pay for service, transfer shall be required promptly when condition of patient permits, and where type of treatment is such that patient may be accepted and treatment carried on by another physician without question as to responsibility for prior treatment, and except:

FIFTH: That, where the patient admitted through emergency is in a position to pay for service, and type of treatment has required reduction of fracture, application of case, splint, suturing, or some similar procedure, transfer to another physician or another hospital shall be urged, but made only by mutual consent of the patient and another physician, or the patient and another hospital.

SIXTH: That in no instance shall Baltimore City Hospitals refer a patient in position to pay professional fee to an individual physician, either a member or non-member of the staff of Baltimore City Hospitals.

SEVENTH: That, in accordance with recommendation of the Baltimore City Medical Society, budgetary officials of the City of Baltimore are urged to budget from the general fund to the Baltimore City Hospitals all monies collected at Baltimore City Hospitals as professional fees, to be disbursed in such manner and for such purpose as may be directed by the Medical Advisory Board.

8. *Baltimore County.* There is a contract with Baltimore County under which the County will pay Baltimore City Hospitals for care and treatment given residents of Baltimore County who come to Baltimore City Hospitals requiring emergency care. This covers both Accident Room and In-Patient Service. It must be remembered, however, that this contract covers emergency cases only, and while the hospital reserves the right to determine what are emergency cases, yet discretion in making such determinations must be used. Baltimore City Hospitals must not be in a position where it can be shown that residents of Baltimore County are being admitted for service where case is not actually an emergency. This would ordinarily mean no O.P.D. service for residents of Baltimore County (or other ineligible patients), except where it is following emergency treatment or discharge from hospital. The Revenue Investigator will set up charges and arrange for billing in all such County cases.

9. *Other Counties.* It is to be noted there is no arrangement with other counties than Baltimore County (other than communicable diseases as referred to later) for care of residents of various counties, whether they come as emergency cases or otherwise. It is important, therefore, that patients coming from other counties than Baltimore County be denied other than first-aid attention—except as they may be extreme emergencies. In such instances, there is no other

choice but that service as required be given. Service in such cases should immediately come to attention of the Revenue Investigator who will follow for billing and payment.

10. *All Counties (Communicable Disease).* Responsibility for admission of children with communicable disease rests with the House Officer from Pediatric Service assigned to this admitting responsibility, with whom Screening Officer will confer on receipt of a call. Where patient with Communicable Disease is an adult, responsibility for admission rests with the Medical Service. Patients with communicable disease are taken from most of the counties. They should be accepted, however, only under conditions as approved by the various Counties. These conditions are recorded in a binder carrying a typewritten sheet for each County in the State. A copy is in the hands of all who may have responsibility for admitting patients with Communicable Diseases. Admissions should be made *only* when the request for admission comes through the routine recorded for the County of residence. It is extremely important that residence be definitely established in each instance of call for admission, and that the routine of that County as recorded be followed in handling the request. Payments for service by the County of residence is dependent on strict adherence to the recorded routine for that particular County. Calls for admission coming from Counties having no arrangement for admission—as indicated in the binder mentioned above—should be rejected. No exceptions should be made except as circumstances existing be referred to the Administration, and admission be approved by the Administration.

Responsibility for Admissions and Accident Room Service

The authority for admitting patients for care, either In-Patient, Out-Patient, or Accident Room, always rests with the Administration of the hospital. The responsibility for admissions, however, is being delegated to the Profession under conditions and routines as herewith outlined:

1. The responsibility and authority for determining and implementing policy in administration of the Accident and Admitting Room, in accordance with basic principles already set forth, is delegated to the Department of Medicine.
   The screening of all patients coming to the Accident and Admitting Room will be done by the member of the Department of Medicine assigned to that duty. Medical Pediatric cases (children under 13 years of age) shall be referred to Pediatrician assigned to Accident and Admitting duty.
   The care and disposition of each patient will be the responsibility of the service involved, as determined by the screening officer—and each service shall assign sufficient staff to be available at all times for duty as required in the Accident Room.
   The member of the Department of Medicine assigned to duty as in #2 above, will also take all outside calls concerning admission of patients, and will have authority to dispose of such calls, including admission of patients and ordering ambulance for patients—where either or both are indicated. Calls concerning Medical Pediatric cases should be referred to the Pediatrician on call.

Tuberculosis Patients

There is an arrangement under which the Tuberculosis Bureau of the Department of Health assigns patients with Pulmonary Tuberculosis (adults) for admission to Baltimore City Hospitals. The Bureau works direct with the Tuberculosis Division of Baltimore City Hospitals concerning such admissions. Any calls from doctors, other hospitals, or other sources, concerning admission of a patient with Pulmonary Tuberculosis should, therefore, be referred to the Tuberculosis Bureau of the Department of Health. Where request comes from another hospital or agency for admission of a patient with Tuberculosis for chest or other surgery, and the patient for whom admission is requested has residence in Baltimore City, and where assurance is given that patient will be accepted in return when surgery is completed, such patient may be accepted without referral to the

Tuberculosis Bureau of the Health Department. There will, no doubt, come to our Accident and Admitting Room, as emergencies, patients with Pulmonary Tuberculosis, where condition of the patient will leave no choice other than admission. Such admissions should always be reported to the Tuberculosis Division of the hospital.

Accident Room Service

Patients given emergency care in the Accident Room—either because of condition resulting from accident, or because of other illness—who are to come back for check or follow-up care should be given appointment for return to the Out-Patient Department and *not* to the Accident Room. Exceptions to this would be where the patient is to return for routine administration of penicillin by a nurse. When the doctor giving emergency treatment wants to see the patient on return, this fact should be noted on the appointment slip and personnel in the Out-Patient Department will call the doctor when the patient reports. The Revenue Investigator will pick up all of these returnees and examine for eligibility and possibility of collection for service.

Industrial Accident Patients

These patients are always fully covered by insurance—both as to hospital cost and professional service fees. It is important, therefore, in connection with these cases, that the memorandum approved by the Medical Society and Baltimore City Hospitals, quoted previously, be kept in mind and the conditions therein adhered to.

Chronic Patients

Many admissions will be made to the Chronic Divisions by transfer from the Infirmary Division or the General Hospital. Responsibility for such transfer is a professional one. The Revenue Investigator, however, should be informed such transfer is being made. When receiving calls from outside concerning admission of a patient chronically ill, screening officer—after determining patient is proper type for admission—shall refer to the Revenue Investigator for determination as to eligibility.

Infirmary Patients

A limited number of patients will be admitted to the Infirmary Division by transfer from other divisions of the hospital. All such transfers must first be cleared with the Supervisor of the Infirmary Division. Admissions to the Infirmary Division from outside—with only rare exceptions—shall be made only on permit from Intake Division of the Department of Welfare. Supervisor of the Infirmary Division will work with the Department of Welfare concerning such admissions, and must pass on any exceptions to this routine.

Exceptions to Conditions of Eligibility

Except as provided in this statement of policies and routines, no physician or other member of our personnel has authority to change conditions of eligibility, or make exceptions thereto.

General Conditions and Comment

Drug addicts, Psychotics and other mentally disturbed patients, Alcoholics, and any other patients in similar categories, are usually not admitted, and are presumed to be problems for the Police and State Mental Hospitals. Real emergencies coming within these categories are, of course, to be looked upon in the same way as other emergencies and handled accordingly.

A patient—even though ineligible under conditions as set forth—may be admitted as either an Out-Patient or an In-Patient where a Chief of Service requests such admission because of unusual clinical interest or teaching value. Such admissions must be made individually, however, and not on basis of category. Clearance on such admissions must be made with office of the Superintendent in advance.

An all-out continuing effort should be made

by all concerned to get complete and accurate information on all patients seen. It is extremely important that the name and address be complete and accurate, and that all other identifying information called for on the "Green Sheet" be recorded completely and accurately. Patient should always be asked if he or she is a Veteran, and the correct answer noted. Of course, it is equally important that professional findings be noted and that any treatment or advice given be properly recorded.

Everyone will recognize the fact that contacts made in our Accident Room and Admitting areas have a tremendous effect on what the community thinks of Baltimore City Hospitals. This fact should be kept in mind by all who have any part in our Accident and Admitting services.

Finally, it is recognized that even with all of the above, there probably are some areas not completely covered by this statement of policies and routines. The Superintendent can be reached almost any time, and stands ready to help in making interpretations or decisions. He will ordinarily support decisions made by the Admitting Officer. In those rare instances when he may reverse a decision already made, it will be because of pressing circumstances over which he has no control.

MEDICAL DEPARTMENT OF THE BALTIMORE CITY HOSPITALS

GEORGE S. MIRICK, M.D.*

The gradual evolution of the Baltimore City Hospitals from a nineteenth century almshouse to the present group of modern hospitals is recorded step by step in annual reports to the Mayor and City Council of Baltimore. From the year the hospital opened in 1865 to 1899 these reports were included in those of the Trustees of the Poor, from 1900 to 1934, in the Reports of the Supervisors of City Charities, and since 1935, in the Reports of the Department of Public Welfare which was established that year.

The facts and commentaries continued in these annual communications reflect the social, economic, and scientific changes which have occurred throughout the last ninety years. It is the purpose of this article to consider the evolution of the department of medicine. The history of the hospital as a whole, is covered elsewhere.

In 1865, we find that 1022 patients of all sorts were treated in the Baltimore City Almshouse, as the hospital was then called. Rather poor conditions are suggested by the statement that many of these patients "eloped" before treatment could be concluded.

The report of 1871 shows that the hospital's name had changed to Bay View Asylum and that 1551 medical and surgical conditions were cared for that year. An additional 246 patients were hospitalized for insanity. The diagnoses listed throw light on the state of medical knowledge which then prevailed. Fever, for example, was a diagnosis and classified as cerebral, congestive, intermittent, typho-malarial, remittent, typhoid or typhus. Thirty-eight patients were admitted with the diagnosis of "debauch" and many others were merely diagnosed "marasmus" or "moribund." No pathological studies were made at that time so no certain diagnoses were established. Costs that year for total medical care in the Asylum were $1.74 per week per patient which compared "favorably" with $6.51 per week at the Pennsylvania Hospital and $12.70 per week at Massachusetts General Hospital.

The entire professional staff that year ap-

* Physician-in-Chief.

parently consisted of two visiting physicians and an apothecary.

There is little information as to the types of therapy employed, but in the report of 1883 we find that the hospital bought 206 gallons of whiskey at $2.33 per gallon, a ration of more than a pint per patient admitted. By 1887 the whiskey consumption had increased to 528 gallons or over a quart per patient admitted but, in the interest of economy, it is gratifying to note that the cost of this commodity was reduced to $1.85 per gallon. The professional staff by then consisted of two resident physicians and eight attending physicians and an equal number of surgeons.

In 1889, The Johns Hopkins Hospital opened its doors and one sees many familiar and now famous names mentioned in the report of the Trustees of the Poor for 1888. A committee headed by President Daniel Coit Gilman of Johns Hopkins University presented "in-door games" to the patients at Bay View. "Among the scientific and professional gentlemen who assisted and advised in the year's work are principally Professor G. Stanley Hall, Professor W. H. Welch, Drs. William T. Councilman, James Carey Thomas, Henry M. Thomas, G. M. Halsted and Dr. E. Cowles." In that year, too, is the first note of a resident house staff consisting of twenty graduate students.

For the first time, in 1893, we find that medical and surgical diseases are separated in the reporting. In that year just under 2000 medical diseases were treated, but the number of patients is not indicated. The much more detailed and accurate diagnoses listed that year as compared with previous years, probably reflect the universal rapid advances that were being made in the field of medicine at that time, and particularly the influence of the new Johns Hopkins Medical School which opened that year. It is of interest that the mortality from lobar pneumonia in the Asylum in 1893 was 31%, whereas it had been quite consistently over 50% in earlier years.

The report of 1896 indicates that the medical staff had grown to a resident physician, two assistant residents, two clinical assistants and ten visiting physicians. For the first time a graduate head nurse was mentioned. That year 2371 medical diseases were treated. A major need was a separate building to isolate the 174 tubercular patients.

The next year, 1897, a hospital annex was opened for chronic senile cases with a separate floor for consumptives. This allowed more space for the medical and surgical departments and a total of 2836 such patients were treated with 2553 medical and 814 surgical diseases.

The report of 1899 dwells at length upon the "atrocious barbarities" of the captains of the oyster boats. Their crews, mostly from New York, once on board were never allowed to come on shore again but transferred from one vessel to another until physically exhausted, completely wrecked, frost bitten and abused they were cast on the shores of Maryland or Virginia until sent to the Bay View Asylum for care.

In 1911 began a new era. "The new hospital, known as Ward A, after long delay was finally opened on the 23rd of August with 73 patients." This was built to accommodate 153 but could hold 180 patients. In addition the general hospital held forty-eight patients, the Infirmary 823, the tuberculosis hospital 159 and the Detention Hospital for the Insane 471 patients. In that year Dr. Thomas R. Boggs, having finished ten years of residency training at The Johns Hopkins Hospital, was appointed Associate Professor of Medicine by The Johns Hopkins University and Physician-in-Chief at the Bay View Asylum. In the same year Dr. Arthur M. Shipley was appointed surgeon-in-chief and these two men headed their respective services with short leaves of absence for the next twenty-seven years.

The services rendered and needs of the hospital are recorded faithfully in the annual reports. In 1912, the chief diagnostic tools requested were a blood pressure recorder and an x-ray apparatus.

In 1913, the major problem was fly control. The large amounts of manure on the adjacent farm and the lack of screens made these a major pest and led to an epidemic of typhoid fever in the patients. In 1914, the problem was getting telephone service since only one line and no switch board served all the sections of the hospital. In 1915, 1916, 1917, there was still no x-ray though it took a full day for the horse drawn ambulance to get each of the sixty-odd pictures taken annually on Bay View patients at The Johns Hopkins or University Hospitals!

In 1917, Dr. Boggs left for France as Chief Consultant to the Air Force of the A.E.F. and Dr. Thomas Sprunt was acting Chief of Medicine until he in turn was called into military service. Then Dr. Charles R. Austrian served as chief in 1918 until Dr. Boggs' return the following year. In 1918, the x-ray equipment requested six years earlier finally became available but it could not be used for another year because the salary for the necessary technician, $75.00 a month, had been stricken from the budget.

An interesting note on the times appears in the report of 1920 where it was pointed out that the occupancy of the various hospitals "was the lowest average for over thirty years. Some attribute this decrease to prohibition but there is no doubt the high wages and the law compelling children to take care of their old parents has much to do with it."

Whether influenced by prohibition or not, the lag in admissions was not sustained, and from 1921 on, with only minor fluctuations, there was a steady annual increase in medical admissions for the next seventeen years. This increase in service strained all facilities and personnel to the utmost. In an eloquent appeal in 1926 Drs. Boggs and Shipley wrote, "It is impossible—to maintain the morale of a service under the conditions which now exist. This municipal burden cannot be shifted indefinitely on a few devoted people—first and last the solution of our difficulties lies in adequate personnel adequately paid."

Finally, in 1930 we find that the new nurses home is nearing completion and that $2,500,000 are being expended on additions and improvements at the City Hospitals. The new General Hospital was opened in 1935 and medical and surgical patients were transferred from old ward A. By the end of the year the entire capacity for medical and surgical patients was being occupied. A peak for medical admissions of 2300 cases was reached in 1938, the year of Dr. Boggs' death.

Dr. John T. King was selected as physician-in-chief to succeed Dr. Boggs. Through his efforts the important Division of Gerontology was established in 1940. From 1942 to 1945 Dr. King was given leave of absence to serve as consultant to the Army of the United States, and he resigned shortly after his release. In the meantime Dr. C. Holmes Boyd was acting chief and succeeded Dr. King as physician-in-chief until 1952.

Throughout the war years there was a great shortage of personnel in all categories in all hospitals and B.C.H. were no exception. This forced curtailment of the services rendered. During the post war years competition between hospitals for house staff became intense due largely to the continuing doctor draft, and the further competition offered by the public health service and veterans administration. The continued shortage of house staff continued to curtail the activities of the medical department. In 1950, the Sydenham service, carrying responsibility for most contagious diseases in the State, was transferred to the departments of Medicine and Pediatrics at Baltimore City Hospitals. In the same year the new out-patient building was completed but the limited staff prevented the medical department from using this new facility at that time.

Throughout the years, especially since 1935, patients at Baltimore City Hospitals were used in teaching the students from Johns Hopkins University and the University of Maryland Medical Schools. This is a logical development since the art of medicine must be learned at the

bedside and the rising cost of medical care in all private hospitals must ultimately result in fewer and fewer service beds and patients who may be used for teaching. Moreover, the general change in the character of disease as seen in any general hospital puts more and more emphasis on the geriatric and chronic forms of illness which at present, in Baltimore, can usually be treated only on an out-patient basis or if hospitalization is required, in a chronic hospital such as that found at Baltimore City Hospitals.

The teaching program was handicapped, of course, by the gross understaffing of the hospital. In 1952, it was decided that the positions of Physician-in-Chief and three Assistant Chiefs be put on a full-time basis. With these positions filled it has been possible to carry out a more active teaching program both at the undergraduate and postgraduate level.

At the present time the 3rd year students from Johns Hopkins receive about ½ their total practical experience in medicine, as clinical clerks, on the wards at Baltimore City Hospitals and 3rd year students from the University of Maryland receive an equivalent share of their instruction at this hospital. The University of Maryland has implemented this program by supporting a fourth assistant chief in medicine.

The present medical staff of the hospital consists of a physician-in-chief (full-time), four assistant chiefs (full-time), sixteen visiting physicians, twenty assistant visiting physicians, seventeen consulting physicians, a visiting neurologist, three assistant visiting neurologists and two visiting psychiatrists. All have appointments on the faculties of The Johns Hopkins University or the University of Maryland or both.

These developments have made it possible to compete successfully with other hospitals for interns on the matching plan and for senior resident staff. At the present time there is a complete complement of twenty-one house officers in "straight" medicine which covers the general hospital and other divisions of the department. The annual number of medical admissions to the Acute Hospital have nearly doubled since 1952 to a current rate of about 1600 per year.

In 1953, the medical out-patient department opened and the patient visits have steadily increased to about 900 per month at the present time. Specialty clinics have been established in neurology, rheumatology, hematology, dermatology, endocrinology, chest and heart diseases, hypertension and kidney diseases.

In 1954 the responsibility for the accident room, with about 3000 patient visits per month, and for screening all admissions to the acute and chronic hospitals, according to the policies outlined elsewhere, was given to the medical department. At present the screening officer, a medical assistant resident, receives all calls from the outside and makes all decisions concerning eligibility according to geography, finances and medical necessity.

The nature and staffing of the chronic hospital is described elsewhere. It should be mentioned here, however, that a new department of Physical Medicine and Rehabilitation is contemplated. In the meantime these activities as well as the growing work in psychiatry are under the department of medicine.

Finally, it should be mentioned that several members of the department of medicine are engaged in active clinical research in the general areas of experimental therapeutics, respiratory and renal disease, endocrinology and virus infections.

Many distinguished physicians have served on the resident medical staff of this hospital. We list herewith only those who have served as chief residents and are still in our community: Dr. W. A. Baetjer (1911–12), Dr. M. C. Pincoffs (1914–15), Dr. N. B. Herman (1921–22), Dr. C. Holmes Boyd (1927–28), Dr. J. G. Arnold, Jr. (1931–32), Dr. Robert Reiter (1935–36), Dr. Julius Waghelstein (1940–41), Dr. H. K. Rathbun (1941–43), Dr. David Marine (1950–51), Dr. David Lukens (1953–54), Dr. Barnett Berman (1954–55).

It is our belief that with the continued sympathy and support from the Mayor and City Council of Baltimore and the two medical schools that the Baltimore City Hospitals can continue to improve its services to the community and to medical education.

Baltimore City Hospitals
Baltimore 24, Maryland

THE CHRONIC MEDICAL SERVICE—BALTIMORE CITY HOSPITALS

ELIZABETH STRAWN, R.N.,* WORTH DANIELS, JR., M.D.,† AND DOUGLAS CARROLL, M.D.‡

The patients in the Chronic Hospital fall into two categories:

1. Those in for custodial care. This group is made up largely of patients with generalized cerebral arteriosclerosis or incapacitating cerebral vascular accidents. A few patients with carcinoma are in this group.

2. Patients requiring active therapy over long periods of time. Patients with rheumatoid arthritis, renal, heart, respiratory or hepatic failure, leukemia, and chronic skin disease make up the majority of this group. Some of these patients will be discharged after prolonged treatment.

Both categories of patients require skilled nursing care. The second group requires frequent medical attention.

The rapid and continued increase in hospital admission of patients with chronic illnesses calls for more information on how this problem is being met at different hospitals. At the Baltimore City Hospitals, nearly all medical patients are admitted to the acute medical service for diagnosis and evaluation. Patients with known tuberculosis are sent to the Tuberculosis Sanitarium, and a few with chronic diseases are sent directly to the Chronic Hospital. After evaluation in the Acute Hospital, patients who will prolonged rehabilitation are sent to the Chronic Hospital. Patients who are able to walk and take care of themselves are sent to the Infirmary if they are too frail or aged to return to productive life.

On March 1, 1955 there were 220 patients on the Chronic Medical Wards at the Baltimore City Hospitals. There were eighty-one white men, fifty-six white women, fifty-four colored men and thirty colored women. About fifty-six per cent of these patients had been admitted since the beginning of 1953. Table 1 shows the year of admission for each patient.

The diagnoses on the various patients are shown in Table 2. It will be noted that cardiovascular disease (largely hypertensive heart disease), cerebral vascular accidents, and diffuse cerebral arteriosclerosis were particularly common, accounting for seventy-one per cent of all diagnoses. The primary diagnosis indicates the major reason for the patients' hospitalization. Since many patients had several major diseases, the secondary diagnosis was also included.

Table 3 shows what the patients were able to do for themselves. Where it was felt that the patient could walk even a few steps, he was classified as being able to walk.

Patient age by decades, sex and color is given in Table 4 in the cases in whom the information seemed reliable.

Table 5 shows the admissions, discharges, transfers and deaths during the last six months require custodial care, prolonged treatment or of 1954. It will be seen that eighty-two patients were discharged, transferred out or died during

* Assistant Director of Nurses, Baltimore City Hospitals.
† Medical Resident, Chronic Hospital.
‡ Chief, Chronic Hospital.

TABLE 1

Admission Years of Medical Patients in Chronic Hospitals

1917	1	1946	3
22	1	47	6
34	1	48	3
36	1	49	10
37	1	50	14
40		51	16
41	1	52	27
42	3	53	43
43		54	62
44	3	55	19
45	5		—
			220

TABLE 2

Primary and Secondary Diagnoses on Medical Patients in Chronic Hospital

Diagnosis	Primary	Secondary
Respiratory		
Tbc		
Non-Tbc	11	0
Cardio-Vascular	49	28
Hemic & Lymph.	4	0
Digestive	5	0
Urogenital	1	0
Endocrine	3	12
Neurological	9	1
Strokes	55	2
Cerebral A.S.	51	3
Psychiatric	5	0
Allergy	0	0
Derm. & Syph.	2	4
Cancer	6	2
Other	20	3
Arthritis	10	2
Amputee	7	0
Blind	3	1

this period. This is thirty-seven per cent of the total population. About one-half of these eighty-two patients had entered the Chronic Hospital during 1954 and three-quarters during 1953 and 1954. It will be seen then, that there is a rapid turnover of recently admitted patients, with a slow accumulation and slow turnover of patients who have been in the hospital over two years.

PROFESSIONAL STAFF

1. *Physicians:* Patients with chronic disease make up a large proportion of any general or specialized medical practice. It is considered wise

TABLE 3

Patient Care Status of Patients on the Chronic Medical Service

Walk	Bathe	Feed	Continent	No of Patients
+	+	+	+	61
−	+	+	+	44
+	−	+	+	3
+	+	−	+	1
+	+	+	−	3
−	−	+	+	5
+	−	−	+	1
−	+	+	−	12
+	−	+	−	8
−	−	+	−	23
−	−	−	+	7
+	−	−	−	1
−	−	−	−	45

\+ Means can walk, bathe, feed and is continent.
− Means cannot walk, bathe, feed and is not continent.

TABLE 4

Age by Decades, by Sex and Color of Patient on the Chronic Medical Service

Decade	WM	WF	CM	CF
30–39			1	1
40–49	2	1	4	1
50–59	6	4	11	3
60–69	25	8	10	6
70–79	21	17	18	9
80–89	19	14	10	7
90–99	6	7		1

to rotate housestaff from the acute medical service through the Chronic Hospital as part of their training in general medicine. Each member of the medical housestaff spends about two months on the chronic medical wards. In the coming year it is planned to have each intern of the acute service assigned a group of these patients in the Chronic Hospital to follow for the whole year. This will provide continuity of care and the opportunity for long range observation which is so important in understanding chronic illness.

The patients seen in the Chronic Hospital are representative of patients seen in private practice in an older age group. There is an unusual opportunity to follow the day-to-day changes inherent in protracted and often irremediable disease. The doctor may profit greatly by evalu-

TABLE 5

Movement of Patients into and out of the Chronic Medical Service, with Diagnoses on Discharge

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Total—6 months
Admissions	7	5	5	4	3	5	30
Discharges (not including deaths)	7	4	5	2	2	5	25
Transfers in	7	8	5	13	5	7	45
Transfers out	3	3	4	6	3	3	22
Died	7	5	5	8	6	4	35
Autopsy %	57%	60%	60%	25%	33%	50%	46%
Diagnosis on Discharged Patients (including deaths)							
Resp.							
Tbc			1				1
Non-Tbc	1	1			1		3
Cardio-Vascular	4	1	2	6	2	4	19
Hemic & lymph			1	1	1		3
Digestive	1		2	1	3	2	9
Urogenital	1		1				2
Endocrine						1	1
Neurological		1	1	2		1	5
Strokes	2	3		4	1	3	13
Cerebral A-S	2			2		2	6
Psychiatric	2	1	1				4
Allergy							
Derm. & Syph.							
Cancer	1	2	1		1		5
Other							

ating patients with multiple disease and complicated histories. His ingenuity is challenged in the management of these patients. Under proper supervision of visiting men interested in the care of chronically ill patients, the intern has the opportunity to develop an optimistic yet realistic attitude toward chronic illness and to learn to understand elderly people. At the same time he has all the facilities of the acute hospital to call on for special help in diagnosis and treatment.

In the future it is hoped that medical students can be rotated through this service for special training in the diagnosis and management of chronic illness.

Although personnel for recreational and occupational activities, physiotherapy and rehabilitation are not at present available, it is hoped that these facilities will become part of the overall organization for the care of the chronically ill.

2. *Nursing:* The quality of nursing care is of tremendous importance in geriatric hospitals. Five registered nurses are assisted by fourteen practical nurses at the Baltimore City Chronic Hospital. Their service to the hospital averages eight years. There are eight nurses aides.

The principal reward of working with chronically sick people is the personal relationship between nurse and patient. This may be as important for the patient's well being as the medication he receives. This type of nursing appeals to the mature serious minded practical nurse.

Baltimore City Hospitals
Baltimore 24, Maryland
(Mrs. Strawn, Dr. Daniels and Dr. Carroll)

THE SURGICAL SERVICE OF BALTIMORE CITY HOSPITALS

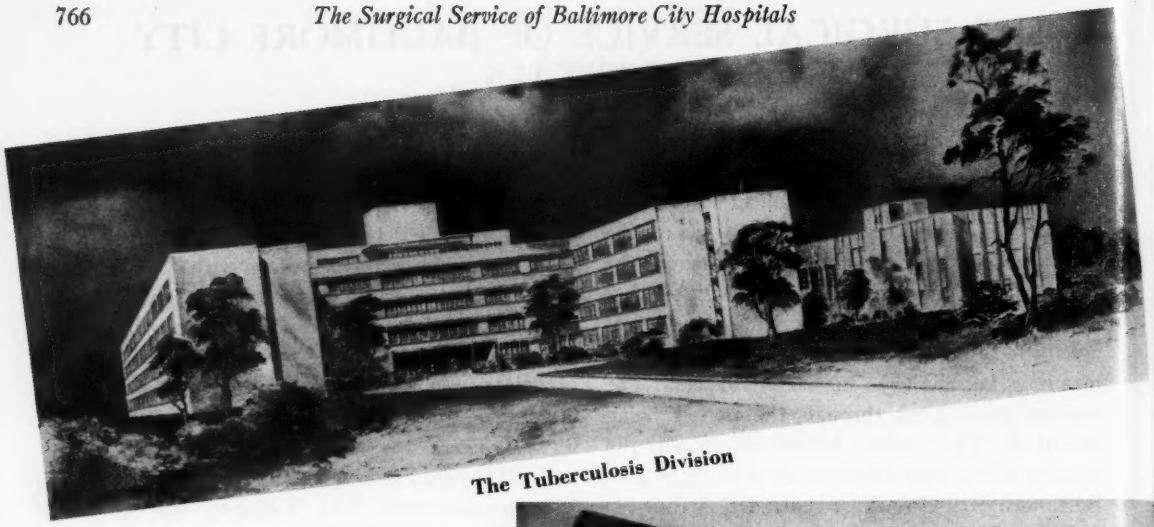
A. M. SHIPLEY, M.D. AND O. C. BRANTIGAN, M.D.*

It is not an easy task for clinical surgeons to become historians. It is difficult to record the facts since the memory of events varies and the importance of one face as compared with another differs with each person queried. The factual events recorded and the interpretation of their meanings become even more controversial. The authors have lived through the period being described. The senior author organized the surgical service and was the first chief surgeon at Baltimore City Hospitals. When Dr. Arthur M. Shipley retired on May 4, 1939, he was succeeded in this capacity by Dr. Thomas B. Aycock who died prematurely on January 7, 1948. He in turn was succeeded as chief surgeon by Dr. Otto C. Brantigan, the junior author, who has been continuously connected with the surgical service since his appointment as a rotating intern in 1933. It is relatively easy to record past events and it is simple to describe the present situation, but it is impossible to predict the future. However, the future of the surgical service at Baltimore City Hospitals seems most promising especially if the past can be used as a yardstick for calculating future progress.

In 1909, Mayor J. Barry Mahool of Baltimore City appointed a committee to study the medical problems at the Bay View Hospital, now known as Baltimore City Hospitals. The senior author was a member of this committee. The physical plant at that time consisted essentially of three main buildings, the Almshouse and two psychiatric buildings. The Almshouse was situated at the top of the hill in a long building surmounted by a dome. The light in the dome served as a landmark for sailors on the Chesapeake Bay and the Patapsco River. This building recently has been renovated and the dome removed. It is now known as the Infirmary Building. The other two buildings, one for men and the other for women, were known as the I.D. (insane department) Buildings. Both of these structures were torn down with the abandonment of the service in psychiatry. There was a building used for infectious diseases which was not a part of the Bay View Hospital. With the organization of medical care on a sound basis this building became the beginning of the tuberculosis service. There was no organized medical care until the recommendations of the committee were implemented. The Y-shaped red brick building known as Ward A, was constructed on the recommendation of the committee. Dr. Arthur M. Shipley was appointed chief surgeon on January 1, 1911 and an organized medical and surgical service moved into the newly completed building, Ward A, on July 1, 1911.

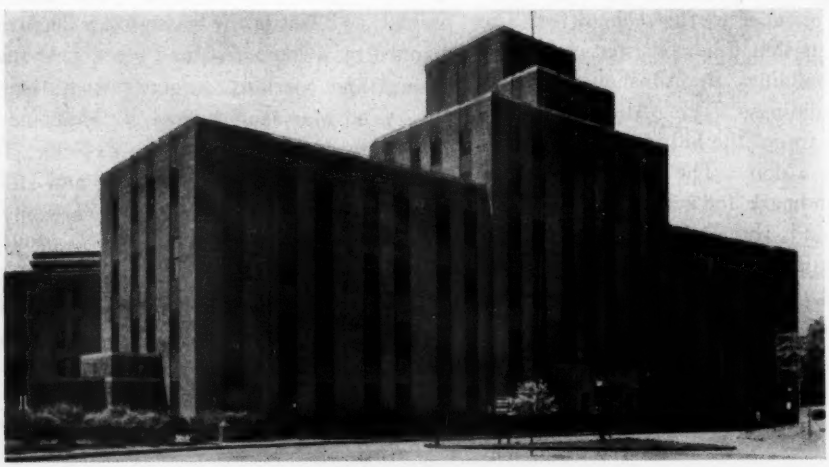
With the development of organized medical care in 1911 there were five services: medicine was headed by Dr. Thomas R. Boggs; tuberculosis by Dr. Gordon Wilson; pathology by Dr. Milton C. Winternitz; psychiatry by Dr. Esther Richards; and surgery by the senior author. Psychiatry was the only service abandoned and plans for its restoration are being considered. The other services, with the exception of surgery, have been reorganized and at the present time are progressive and staffed by full time doctors. The surgical department is at present, as it was in the beginning, a department manned by a competent and recognized staff of general and specialty surgeons from the University of Maryland School of Medicine and The Johns Hopkins School of Medicine. These surgeons were from the beginning and still are part time gratuitous workers. There are only two salaried part time members of the staff, one of whom has been available for only the past year. Under the leadership and careful planning of Dr. A. M. Shipley the surgical department has developed and progressed and at times came to the

*Chief, Surgical Service.

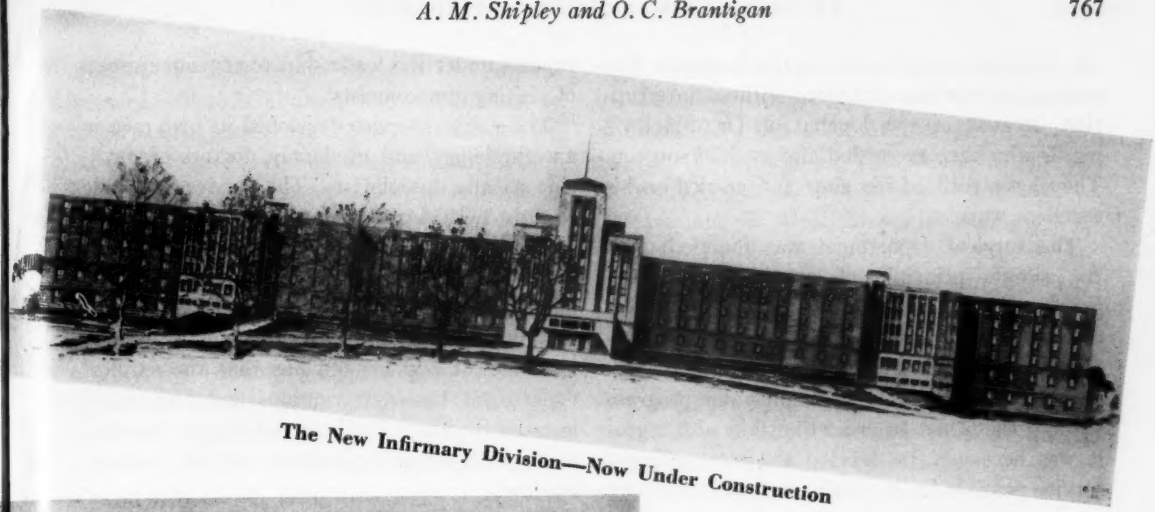


The Tuberculosis Division

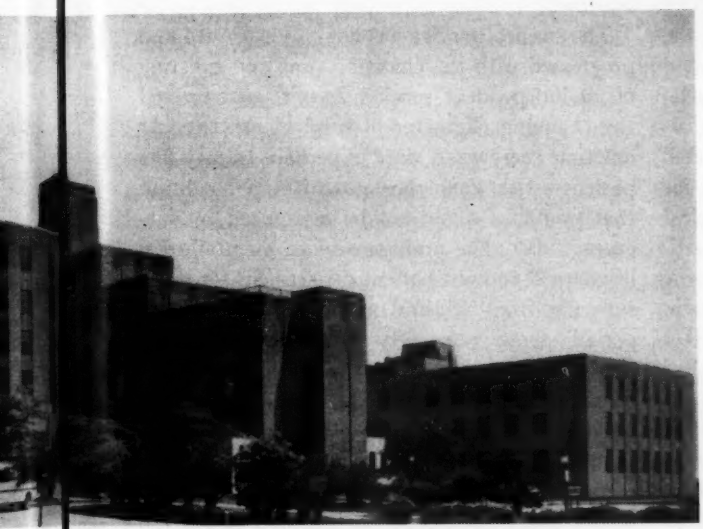
The General Hospital and Out-Pa



The Hospital for Chronic Diseases



The New Infirmary Division—Now Under Construction



ospital ut-Patient Department

Nurses' Home

aid of other departments of the hospital. The surgical service has continued without interruption because of the loyalty of Dr. Shipley's pupils who have succeeded him as chief surgeon. They have realized his aims and carried on his excellent work.

The surgical department was founded upon the simple principle of providing the best possible surgical treatment for the indigent sick of Baltimore City and the finest training available for medical students and house officers. It would be difficult to accomplish one program without the other. In order to attain such a goal it was necessary to develop the most efficient service possible in the profession. As the service grew and as medical science improved the surgical department was able to beget, foster and encourage the development of other independent departments by separating the specialties from the surgical service. From 1911 until March 1935, when the new hospital building for acute diseases was put into service, the surgical department took care of obstetrics and pediatrics. For years it had become obvious that the surgeon should not practice obstetrics or serve in prenatal and post-natal clinics. In order to better minister to the needs of the indigent sick of Baltimore City independent departments of obstetrics and pediatrics were organized in 1935 and these specialities were separated from the surgical service. It was a big step forward to remove this responsibility from the surgical service and place it in the hands of competent specialists.

Gynecology was developed along specialty lines by the surgical department, utilizing only recognized and trained gynecologists (not combined obstetricians and gynecologists), for female pelvic surgery. The outgrowth of a specialty service in gynecology was one of the earliest developments of this type in the country. The surgical department is proud of the fact that on July 1, 1953 the department of gynecology was separated from surgery and has continued to expand under the leadership of the same group of visiting gynecologists.

The surgical service developed its own men in anesthesiology and used only doctors of medicine as anesthesiologists. The service was able on July 1, 1953 to detach from itself the department of anesthesiology. The surgical department also was able to develop a physical therapy unit and is looking forward with pleasure to establishing it as a new department of physical medicine. It appears obvious that the surgical department has been vigorous and progressive in order to play a dominant role in the development of these new departments without destroying itself.

The surgical service has not only survived and progressed with the changing time and splitting off of independent services but it has survived the changing character of surgical practice. At one time there was a ward of perhaps twenty-five patients with gonorrheal arthritis, a condition that probably would not be recognized by surgeons today. The urologic service maintained a large ward and out-patient department for those suffering from urethral strictures. During one period, there were fifty-four patients on the chronic surgical service with ununited fractures of the neck of the femur. There were many patients with tuberculosis of the spine. The change from such practices to all present day methods, including cardiovascular surgery, has been accomplished in stride. The decrease in the number of patients from a high census of about 130 acutely ill patients to a low of about thirty-five such patients has been effected without disruption of the service. The reduction in the number of patients is the most difficult obstacle to overcome.

In the beginning of the surgical service a great and fundamental decision had to be made. The question arose as to whether the house officers in surgery were to be spoon fed and taught surgery by being allowed to watch a visiting staff of accomplished surgeons do the

bulk of the surgery or whether the surgical trainees were to be allowed to learn by doing the surgery themselves under visiting staff supervision. It was believed by the senior author and supported by the two successive chief surgeons that the latter plan was more desirable. It was thought unwise to inaugurate a training program whereby the surgeon finished his training without doing any surgery on his own responsibility. Shortly after the initiation of this program in surgery the training period of five years was established. Under such a plan the resident was necessarily qualified to do surgery. Consequently, when the American Board of Surgery was organized in 1937 the surgical training program was approved and it has remained fully approved.

It was soon evident that in order to accomplish the goal of the best possible care to the indigent sick and the finest training for house officers, it was necessary to develop specialty care as well as a good training program in general surgery. A surgical specialty service, as an independent department, must have a required minimum number of patients. It has been obvious that an adequate patient load has not been and is not now available for autonomous surgical speciality services. However, the future may provide sufficient patients to establish independent or autonomous services in part of or all of the surgical specialities. It has been demonstrated that specialty care can be provided under general surgery. The acme of the plan has shown its foresightedness in gynecology. When a service becomes large enough, it can be launched on its independent course. The surgical department has developed specialty care to a high degree and yet has held intact its program in general surgery. There are American Board approved services in the following specialties: neurosurgery, orthopedic surgery, urologic surgery, thoracic surgery, ophthalmology and otolaryngology. There are other less well developed specialities such as plastic surgery, rectal and colon surgery and hand surgery. The specialties are headed by outstanding men in their particular fields: Dr. James G. Arnold, Jr. in neurosurgery, Dr. Allen F. Voshell in orthopedic surgery, Dr. John D. Young in urologic surgery, Dr. William G. Marr in ophthalmology, Dr. John E. Bordley in otolaryngology, Dr. C. Parke Scarborough in plastic surgery, Dr. James C. Owings in rectal and colon surgery and Dr. Raymond M. Curtis in hand surgery.

The trainee in general surgery rotates through the various specialities as well as in general surgery. For three or four months he works full time in the department of pathology at Baltimore City Hospitals. For two months he works full time in experimental surgery at the University of Maryland School of Medicine. He is given a one semester course in surgical anatomy, and a two semester course in basic science at the University of Maryland School of Medicine. Each of the American Board approved specialty services has only one specialty house officer on the service and he serves as resident of the specialty service. The young doctor beginning his training in general surgery has an opportunity to develop into the resident in general surgery or to transfer to one of the approved surgical specialty services. The diagnostic division of the surgical service and that of the hospital generally are first-rate and all the practical and latest diagnostic procedures can be carried out. This gives the trainee unlimited opportunity for his own development.

The surgical department has done a considerable amount of clinical investigation and research. Its accomplishments are many and it is impossible to recount their efforts completely or adequately. However, a few will be mentioned. Under the guidance of Dr. Edward A. Looper, the bronchoscopic treatment of postoperative atelectasis was carried out long before it was a generally recognized method of treatment; nonobstructive tracheotomy was used routinely several years before its description in the liter-

ature. The surgery of tuberculosis in the State of Maryland was placed on a practical basis under the able leadership of Dr. Thomas B. Aycock years before it was generally accepted in this country. Routine bronchoscopic examination of patients with pulmonary tuberculosis was first done at Baltimore City Hospitals. The orthopedic service under competent leadership performed the first nailing of a fractured hip in the City of Baltimore. This led to the elimination of the ward of ununited hip fractures. It was the first service in the city to use internal fixation and ambulatory treatment of fractures. A program of vertebral fusion eliminated the problem of tuberculosis of the spine. Cervical vertebral fusion was carried out long before it was done elsewhere. The surgical fusion of a Charcot knee was accomplished successfully when there was only one case report in the literature. Bilateral lumbar sympathectomy was first done at Baltimore City Hospitals. Our own investigations first proved that postoperative pulmonary complications were more common after spinal than after general anesthesia. The surgical department developed the first x-ray operating room in the United States and it has been highly successful. This department established the third blood bank in the world. The first was started by the Cook County Hospital in Chicago, the second by the Johns Hopkins Hospital, and only one month later the blood bank at Baltimore City Hospitals was put into use. The surgical service originated, conducted and manned the facility supplying blood to the entire hospital until January, 1950, when it was willingly turned over to the medical laboratory service where it properly belonged. The surgical service now has in operation a bone bank. It is cooperating with the cornea bank at The Johns Hopkins Hospital through the ophthalmology service. A blood vessel bank is being developed. A skin bank is contemplated but has not yet been started.

Progress of the surgical service has been accomplished with the aid of the able and untiring nursing service. The operating rooms have been well equipped through the efficiency and zealous efforts of Miss Della May. The chronic hospital service has been developed to a degree where patient care is second to none in the country, and the continued efforts and devotion of Mrs. Elizabeth Strawn have played a large part in this development. All chronically ill patients are rehabilitated except those enfeebled by age, patients with terminal malignancy, and those with diseases of the leg such as varicose vein ulcers, peripheral vascular disease both venous and arterial, and simple fibrosis and/or ulcers. Patients with leg ailments remain a real problem in the chronic hospital.

The authors feel deeply indebted and are grateful to the many surgeons who have contributed so much to the development of the surgical service at Baltimore City Hospitals. We would like to single out and name each and everyone of the past and present group of surgeons and give proper credit for what each has contributed. Since this is impossible, the authors wish to take this opportunity to express their sincere thanks to each and every past and present member of the surgical staff.

The past and present administrators of the hospital together with the Mayors and City Council of Baltimore City deserve a great deal of credit and commendation for their part in supplying the monetary and physical necessities required to make the surgical progress possible. What the profession had vision enough to seek the authorities have had fortitude to supply. If future events can be foretold by past history the surgical service at Baltimore City Hospitals may look forward to an extraordinary period of great development and a wonderful opportunity to serve the indigent sick of Baltimore City, and at the same time occupy an important place in the development of the surgical profession by teaching medical students and training capable and mature surgeons who can step forth and carry on the profession.

Baltimore City Hospitals
Baltimore 24, Maryland
(*Dr. Brantigan*)

HISTORY OF TUBERCULOSIS DIVISION, BALTIMORE CITY HOSPITALS

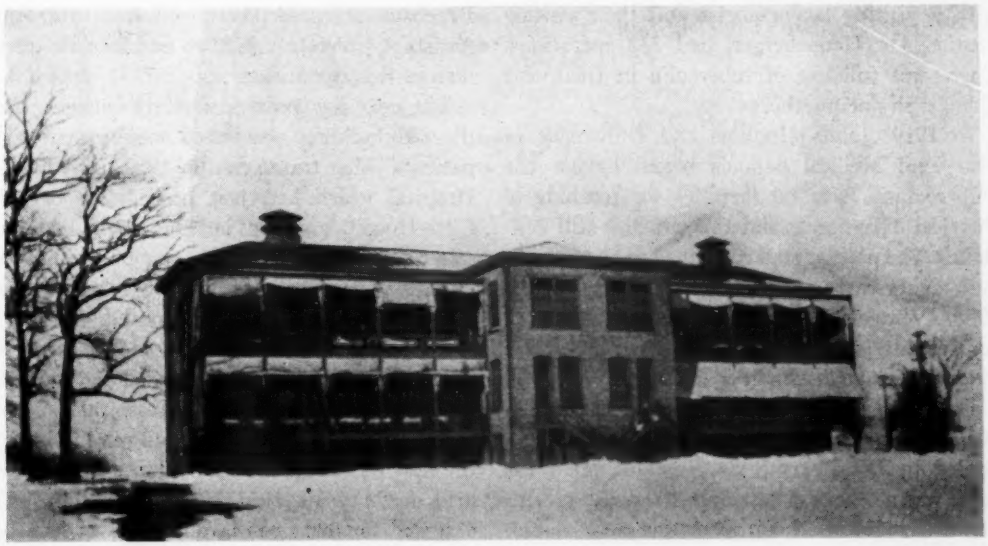
EDMUND G. BEACHAM, M.D.*

In 1890 at Bay View Hospital, Baltimore, there were set aside separate wards for patients with pulmonary tuberculosis. This was probably the first attempt in the United States to have separate tuberculosis wards in General Hospitals.

It was fourteen years later on 19 December 1904 that the Municipal Tuberculosis Hospital was opened to accommodate about 170 patients. At that time, as now, far advanced cases made up the bulk of admissions. Treatment consisted in the main of a good diet, warm clothes and bedding, plus the stimulation of cold air and sunshine, keeping patients out of doors as much as possible.

Dr. Gordon Wilson, later Professor of Medicine, University of Maryland, was the first Physician-in-Charge of the Municipal Tuberculosis Hospital and made his first formal report for 1908. In that year they treated 428 patients with 165 deaths and 125 improved. The diet included three servings of milk and raw eggs in addition to regular meals. In 1909, Dr. Wilson had two assistant physicians and nine nurses to treat 588 patients, of whom 203 died. He remarked in his report that the Baltimore City Health Department helped the general tuberculosis problem by assigning fourteen nurses to Home Nursing of tuberculosis patients. At that time, admissions were by strict compliance with a waiting list. Cost per patient per day was $.49.

By 1911 accommodations were available for 200 patients, and during 1912 there were 679 patients treated. Extra facilities were sought, and Dr. Wilson asked for a new hospital which could



Tuberculosis Hospital at Bay View Asylum

To see the new Tuberculosis Hospital, turn to page 766.

* Chief, Tuberculosis Division.

be converted to a General Hospital if there was a decreased need of beds for consumptives. He also requested fluoroscopic and x-ray equipment in line with developments in that field.

The high point in numbers of patients treated was in 1914 and has not been surpassed. In that year there were 700 patients treated with 239 deaths. Dr. Wilson had built his staff to include five other physicians.

Beginning of World War I slowed the service and in 1917 Dr. Wilson resigned to accept a commission. Dr. Charles C. Hableston took over but left for the service in 1918, and Dr. Harry D. McCarty became Tuberculosis Physician. During that year the patient load dropped to ninety-two. The staff benefited by consultation with a visiting laryngologist and their visiting dentist, Dr. Henneberger, had 232 operations. There was full use of tuberculin in treatment along with pneumothorax.

In 1919, Johns Hopkins and University of Maryland Medical Schools began to use the Tuberculosis Hospital facilities for teaching of Physical Diagnoses, and this practise still continues. The patient load continued to be low with only eighty-three patients on hand at the end of 1923. Average stay was 332 days for that year as contrasted with reported ninety-nine days average stay to discharge in 1909.

Dr. Hableston returned as Chief Physician in 1924 to continue until 1933 when he was succeeded by Dr. Harry Stein. In these ten years there was a census of just over 100 patients with little change in therapy or progress noted. Among the men who served on the house staff were Drs. James G. Arnold, Lawrence M. Serra, and Meyer Jacobson.

January 1936 marked the beginning of another era. A new building was opened plus renovation of the old, and finally by 1938 a total of 280 beds were available. These were set up to handle about fifty per cent each male and female, negroes and whites. Pneumothorax was the predominant therapy with about twenty-five per cent of the patients receiving such treatments.

In 1940, Dr. Stein died and was succeeded by Dr. H. Vernon Langeluttig who was soon called into military service. During the war years Dr. Lawrence M. Serra was acting Chief and handled well a most difficult professional assignment, keeping the census about 240 patients.

In 1946, Dr. Langeluttig returned as Chief of Service and Dr. Alvin S. Hartz was obtained as full time Assistant Chief until July 1947. About this time there was considerable discussion in favor of a new building to replace the one housing negro patients. The Maryland Tuberculosis Association and many other interested citizens helped obtain a bond issue for this purpose. A committee of experts in many fields was formed to plan the new building. Dr. Edmund G. Beacham accepted the position of full time Assistant Chief July 1, 1948 and became Chairman of this committee.

The next few years saw many changes. First the old building was razed resulting in some patients being transferred in 1950 to Sydenham Hospital which had just been taken over by City Hospitals. Then in 1951 Sydenham was sold to the State and one floor of the Chronic Division was utilized to house white male patients. Admissions were limited further as facilities were reduced. The old tuberculosis laboratory and kitchen were razed and food was transported from the General Hospital.

Finally in April 1953 patients were moved to the new building, and dedication exercises were held on May 10, 1953. The new building was designed for 300 beds in one, two, or four bed units. This, with 140 beds remaining in the older building could accommodate 440 patients. The new building has administrative offices, auditorium, and laboratories on the first floor. This includes the Pathology Department for all of Baltimore City Hospitals. There is also a central kitchen featuring production line service and a Meal Pack which can keep food warm several hours. This allows use of small pantries on each floor. Large storage areas in the rear part of this floor offers an opportunity to get

clean equipment for new patients with cleaning facilities for contaminated equipment.

The connecting area between new and old buildings was renovated with development of an additional passageway between the second floor of the two buildings.

There were five nursing units established; two on the second, two on the third, and one on the West end of the fourth floor. Each unit has several utility rooms, pantry, janitor area, toilet, gown room, and connecting nurse station, treatment room and doctor's office. On the East end of the fourth floor is the Dental Suite with two chairs; an x-ray and fluoroscopic section; and an air conditioned Surgical Suite with three operating rooms.

Several features are abundant window area without porches, radiant heating, corridor handwashing facilities, and three central automatic elevators. The building was designed for easy conversion to almost any type hospital facility desired if tuberculosis beds were no longer needed.

Along with plans for the plant, plans for personnel were developed to care for the increased patient load in line with medical nursing and rehabilitation developments. In 1951, a Director of Rehabilitation was furnished by the Maryland Tuberculosis Association, but although the work accomplished had value, the City would not furnish funds to take over the position and it was abolished in 1954.

Our long range plan has been insofar as possible to return patients to the community physically well, mentally prepared, and socially and economically able to return to normal family and business activities. That implies adequate professional staff in the hospital for medical and nursing care, social service consultation service, diversional occupational therapy, and vocational counseling, with other services as needed.

The Nursing Service has been a stabilizing influence under the supervision of Miss Myrtle Dooley who has directed the program since 1938. At present there are four graduate nurses, twenty-nine licensed practical nurses, and about 100 total nursing personnel. It has been difficult to attract graduate nurses in the field of tuberculosis nursing. There is a real need for supervision, direction of staff activity and of patient and nurse education by a sufficient number of professional staff.

As part of the teaching function an affiliation program for three year nursing students has been in effect with Delaware Hospital since October 1953, St. Josephs and Bon Secours Hospitals added in 1955 with the Maryland Tuberculosis Association supplying a full time nurse in Patient Education. This gives an opportunity to establish closer relationship with patients and their families and to increase patient education and understanding of his disease.

Five positions are available for full time physicians including the full time Chief of Service. The resident house staff is augmented with rotating men from the medical service and a position is available for rotating residents from University Hospital. Dr. Edmund G. Beacham was appointed full time Chief in July 1954 with Dr. Langeluttig continuing to offer his valuable advice as consultant.

A comparison of patient load during the past nine years will show the constantly decreasing mortality and the markedly decreased rate of irregular discharge. This rate is still too high but in a municipal institution is considered an excellent attainment.

Year	Deaths	Total Discharges	Regular Discharges	Irregular Discharges	% Irregular	Admissions
1946	165	173	80	93	56	330
1947	146	191	65	126	66	303
1948	118	143	77	41	46	183
1949	80	142	107	35	25	184
1950	84	118	104	14	12	203
1951	60	124	99	25	20	190
1952	37	119	86	33	28	145
1953	32	148	120	28	19	213
1954	32	203	148	55	27	291

Until opening of the new building the census showed about 50% each negroes and whites. At present there are about 70% negroes, mostly males. This is brought about because negro patients can be admitted only at Henryton Sanatorium and City Hospitals plus a very few post surgical patients at Mt. Wilson. This hospital has kept its census at 300 because of budgetary reasons and has not opened the old 140 bed area nor the surgical suite as yet. Admissions are chiefly through the Director of Tuberculosis of the Baltimore City Health Department.

Medical therapy has changed considerably since 1947 and almost every patient receives two or more of a combination of streptomycin, izoniazide, para aminosalicylic acid and viomycin. About one-third of the patients are on pneumoperitoneum at any one time. Resectional therapy is the surgery of choice. Many patients leave the hospital to continue anti-tuberculosis drugs on the outside.

Surgical procedures may be compared with those of Sea View Hospital, New York, which cares for a similar group of patients with high percentage of non-white far advanced cases.

B.C.H. (Tbc. Div.), 1946–1953

	Number	Deaths	%	Broncho Pleural Fistula
Thoracoplasty	123	11	9	
Resection				
Lung	29	7	24	2
Lobe	24	5	21	1
Segment	17	1	6	
Total Resections	70	13	19	3

Sea View—Excisions, 1944–1952

	Number	Deaths, %	B.P.F., %
Lung	333	20.7	14.1
Lobe	150	17.3	21
Segment	29	10.7	14.3
Total Resections	512	19.9	16.2

There has been a shift in ages over the years, and in February 1955 a review of hospital population revealed the following:

Admission	CM	CF	WM	WF	Total	%
12–20	7	24	3	2	35	12
21–30	29	27	1	10	67	23
31–40	27	23	5	11	57	23
41–50	36	5	17	4	62	21
51–60	23	1	8	0	32	11
61+	11	2	12	2	27	9
Total	133	82	46	29	290	

The important facts are that 80% of white males are over forty and 52% of negro males over that age.

An outstanding advantage of proximity of a tuberculosis hospital to a General Hospital is shown in a summary of consultations given tuberculosis patients discharged in 1954.

Dental	226	Neurology	13
ENT	224	Psychiatry	11
Surgery	114	G.U.	10
Eye	57	Dermatology	8
Medical	25	Orthopedics	7
Obstetrics	16	Pediatrics	1
Gynecology	15		
		Total	727

A further service beginning 1 April 1955 has been two part time psychiatrists from Sheppard and Enoch Pratt Hospital. These physicians are working in patient diagnosis and therapy plus staff education and orientation in psychiatric methods.

An Occupational Therapist has been available continuously since 1953 and offers diversional activities. She can only scratch the surface and needs additional help. Plans are completed for an O.T. school to run in conjunction with that for Affiliate Nurses.

Since February 1953, beauty parlor service has been available through efforts of Baltimore Hairdressers Association. These volunteer

workers have contributed greatly to patient morale.

Of real value in a related field has been the decision of the Department of Education to offer full time help to tuberculosis patients. In 1953, Mrs. Edith Williams was added to the staff; in 1954, Mr. Franklin Bills, both to work with students below high school level. In 1955, the Adult Education Department sent two part time teachers to work with adults, beginning first to teach elementary reading and writing skills. These programs allow students at P.S. #354, our official name, to continue studies uninterruptedly and to return to school later without much loss in time. The Baltimore City Health Department has greatly increased number of admission of school age patients to take advantage of this service. The programs also prepare some patients to take advantage of training offered by Vocational Rehabilitation Service. School #354 has an active Parent-Teachers Association.

In the year ending June 1955 there were fifty-four students enrolled in P.S. #354 with an average enrollment of thirty-nine. In Adult Education there were fifty-one patients enrolled. An outstanding achievement was the announcement that three of our adult male patients has successfully completed a high school equivalency test while in the hospital.

The Maryland State Department of Vocational Rehabilitation has for some years offered counseling but in 1954 increased their program. Two part time workers carried out an initial survey and now offer weekly testing and counseling. Many discharged patients have gone directly into training for new vocations. Plans are being completed to begin classes in typing, later homemaking, and possibly to set up shops for male patients. Some of this latter will be in conjunction with O.T.

The Social Service Department of Baltimore City Hospitals is housed at present in the Tuberculosis Hospital and has centered a major part of its activities there. All patients are seen on admission, at intervals during their stay, for emergencies, and with special consideration at time of discharge. This service has been a very important factor in getting patients into the hospital routine much more easily, in keeping them more relaxed while there, and because of many community resources, in preparing patients for return to the communty. They have played a major role in development of Community Agency meetings. These are held monthly at the hospital in conjunction with the Baltimore City Health Department. Many interested agencies in Baltimore participate in discussion of mutual problems and as a result, much has been accomplished in this vital field.

Enoch Pratt Free Library established a branch in this hospital on November 1, 1953 and has a circulation from the Central Branch. Close cooperation is maintained with our educational and vocational training program. The librarian is maintained by Maryland Tuberculosis Association and has been a most valuable asset. At present he acts as an advisor to the patient monthly magazine "The Hilltop" with a circulation of over 500 and now in its seventh year.

Since 1949, there have been weekly Rehabilitation Conferences of the entire staff including doctors, nurses, social service department, occupational therapist, vocational rehabilitation service, librarian, and chaplain and dietitian when available. These have been fruitful with patients, problems, plans, and policies receiving full critical discussion.

Under existing regulations the tuberculosis hospital is closely tied to the community and its agencies. It benefits greatly from the generosity of such groups as Maryland Tuberculosis Association and Baltimore Tuberculosis Aid Society. It offers to Baltimoreans ill with tuberculosis the best possible chance of controlling their disease.

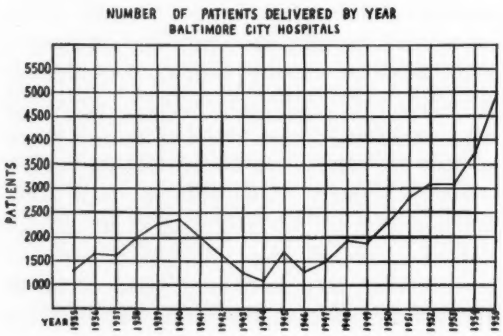
It gives them unprecedented opportunities for social and economic rehabilitation and the privilege of returning as whole persons to take their place in the community.

OBSTETRICAL DEPARTMENT

LOUIS H. DOUGLASS, M.D.*

Prior to the opening of the new hospital in 1935, obstetrics at Baltimore City Hospitals was quite incidental. A few patients were admitted and cared for by the surgical house staff. There was an obstetricial consultant (Louis H. Douglass) who saw the very occasional complicated case.

With the opening of the new hospital, ninety-six beds became available for obstetrics and an adequate staff (nursing, house and visiting) was available for their care. The number of patients at first was small but the service has grown, as indicated by the accompanying graph, until in



the current year it is estimated that some 5,000 women will have their babies at Baltimore City Hospitals.

In recent years the national trend has been towards earlier postpartum ambulation and shorter hospitalization. A management program that required seven to ten days in the 1940's now is completed in two to three days with a surprisingly low morbidity and mortality rate that compares favorably with the best records obtained in the past. The marked change in duration of hospitalization allowed a tremendous increase in number of deliveries with the same facilities.

The house staff at first was quite adequate, but as the number of patients increased and the Armed Forces required more and more medical officers, the supply became much less than the demand. There has been a wonderful spirit among the house officers, and it is only because of this and their willingness to work hard and long that the service has been able to continue. It would appear at this time that the future looks much brighter from the standpoint of house officers. Meanwhile, some of the outstanding obstetricians of Baltimore and other places received a part or all of their training at Baltimore City Hospitals. Among these may be mentioned: Dr. Ferdinand Kadan, Baltimore; Dr. Charles L. Goodhand, Parkersburg, West Virginia; Dr. Arthur Baptisti, Hagerstown, Maryland; Dr. I. I. Dann, Harrisburg, Pennsylvania; Dr. William Dorman, Baltimore; Dr. D. Frank Kaltreider, Baltimore; Dr. Louis C. Gareis, Baltimore; Dr. T. Edgie Russell, Baltimore; Dr. J. Tyler Baker, Easton, Maryland; Dr. Harry Cohen, Baltimore; Dr. Emerson Fackler, Harrisburg, Pennsylvania; and a number of others.

On the visiting staff there has always been equal representation from the two medical schools. Also, there has existed a spirit of complete cooperation among all members of the visiting staff. It is interesting to note that of the six members comprising this group, three are former residents on the service.

On July 1, 1955, a full time Chief of Obstetrics will assume charge of the service. This will result in a much closer supervision of the house staff and the service generally. Also, many structural changes are being planned which will allow the work to be done much better.

Altogether, this division which has grown from infancy to adulthood appears to be extremely healthy and we may expect continued growth and development.

Baltimore City Hospitals
Baltimore 24, Maryland

* Former Chief of Obstetrcis. Paul E. Malumphy, M.D. is the present Chief, Obstetrical Service.

THE PEDIATRIC SERVICE

HAROLD E. HARRISON, M.D.*

Pediatrics at the Baltimore City Hospitals was formally launched in July of 1935. Before that time there had been pediatric consultants to the hospital, the most distinguished of whom was probably the late John Ruhräh, but there was no separate pediatric service. With the opening of the new general hospital building under the newly created Department of Public Welfare, expanded services to the community were offered including both an Obstetric and a Pediatric Division. Pediatrics was formally affiliated with The Johns Hopkins University School of Medicine and with the collaboration of Dr. Edwards A. Park, who was then Professor of Pediatrics at Hopkins, Dr. T. Campbell Goodwin was appointed as the first Chief of Pediatrics at the City Hospital. Although this was a part time position and Dr. Goodwin had an active practice, he quickly organized and developed an effective Department of Pediatrics. Associated with him were Drs. Seabold and Debusky who assisted in the instruction of medical students from the University of Maryland as well as in the supervision of the patients. During the next few years the service grew under Dr. Goodwin's aegis and provided the additional facilities for hospital treatment of children which were sorely needed in Baltimore.

With the outbreak of World War II the Pediatric Service was beset with serious problems. The visiting staff was depleted as physicians were called into the armed services, and in August 1942, Dr. Goodwin was given military leave of absence. The service continued for a year under great difficulty and in August 1953, was closed as a separate unit because of shortage of nursing personnel as well as lack of pediatricians to supervise patient care. This was a source of great distress to Dr. Park who was convinced that good pediatric facilities at the City Hospitals were important and would be increasingly necessary to meet the needs for pediatric care in the community. Dr. Park suggested that the various hospitals in Western Maryland, Southern Maryland and the Eastern Shore be approached to see if they would be interested in sending student nurses to the City Hospitals for an affiliation in Pediatrics. With Judge Waxter, who was Director of the Department of Public Welfare, he spent several days visiting a number of hospitals and found that there was an interest in such an affiliation. Dr. Hugh Josephs was then approached, and he accepted the task of reopening the service and acting as Chief until Dr. Goodwin's return. In March 1944, the Pediatric Service reopened. Dr. Josephs devoted almost all of his time to the City Hospitals, sacrificing his research and clinical work at the Harriet Lane Home during this period. Nursing affiliations with several hospitals were established, and under the conscientious guidance of Miss Dorothy Kottcamp, Supervisor of Pediatric Nursing, an excellent course in Pediatric Nursing for affiliates was developed which has continued and expanded since.

At the end of the war Dr. Goodwin decided not to return to Baltimore and accepted a position as Chief of Pediatrics at the Mary Imogene Bassett Hospital in Cooperstown, New York. A new Chief, therefore, had to be appointed. At this juncture the decision was made to reorganize the service on a full time basis, and the present Chief, Dr. Harold E. Harrison, was appointed in the fall of 1945.

During the first postwar year the in-patient service was increased in scope, and laboratory facilities were added to improve the diagnostic services as well as to permit investigative work. As the pediatric resident staff expanded, the responsibility for the care of the newborn infants was taken over by Pediatrics. This had formerly been the responsibility of the obstetri-

* Chief, Pediatric Service.

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cal staff. The rapid growth of the Obstetrical Service, however, hastened the assignment of the care of the newborn infant to Pediatrics, a policy which has become almost universal in the teaching hospitals of this country. A new premature unit was also equipped on the Pediatric floor with a capacity of twenty-five infants.

The need for more facilities for out-patient care of children in Baltimore meanwhile became obvious. The Out-Patient Departments at the Harriet Lane Home and the University Hospital were being taxed to the utmost. A Pediatric Out-Patient Department was, therefore, established at the Baltimore City Hospitals, and this grew with amazing rapidity reflecting the community need for such services. During 1954 there were over 29,000 patient visits to the Pediatric Out-Patient Department.

The changing pattern of medical needs in the community produced corresponding alterations in the Pediatric Service to meet these needs. In the fall of 1950 the Sydenham Hospital for communicable diseases, which was an agency of the City Health Department, was closed because of the decreased incidence of communicable diseases requiring hospitalization. The task of caring for those remaining infectious disease problems which required hospital care was taken over by the City Hospitals and handled jointly by the Pediatric and Medical Services. Some apprehension was expressed in the community that the City Hospitals' facilities might be swamped if a poliomyelitis epidemic occurred. However, during the summer and fall of 1951 the largest outbreak of poliomyelitis in the history of Baltimore since 1916 occurred. The City Hospitals met this problem in a fashion which was highly satisfactory to the patients and their families, and to the physicians of the community. An Award of Merit from the Mayor was given in recognition of this service. Since then, the Pediatric and Medical Services have continued to care for poliomyelitis and have kept abreast of all new developments in the field. At the present writing, the results of the poliomyelitis vaccine study offer hope that prevention of poliomyelitis may be accomplished in the near future. If so, the Pediatric Service will again reorient itself and use its facilities to meet other medical needs of the children of Baltimore. The communicable disease service, even now, is but a small part of the total pediatric case load.

As a division of the Department of Public Welfare the City Hospitals cares for the large group of children who are wards of the city under the supervision of the Department of Welfare. A Medical Care Clinic for these children has been set up and the Pediatric Out-Patient Department is the center for this Medical Care program.

A number of voluntary organizations have been interested in the activities of the Pediatric Service and have made contributions both of money and of time which have been of great value. The Exchange Club of Highlandtown has set up a Child Research Fund at the City Hospitals which has supported investigations in the problems of the premature infant and in the treatment of nephrosis. The American Legion Auxiliary, Department of Maryland, has presented money for the purchase of an Oximeter and for air conditioning the Poliomyelitis Unit. The Forest Park Child Study Association has equipped a play room for convalescent children and has provided continued cooperation in helping these children by occupational therapy and entertainment. The Baltimore District of the Maryland Federation of Women's Clubs purchased an Infant Respirator for the hospital. Many other organizations have made gifts of various sorts for the benefit of the children cared for on our wards and in our Out-Patient Department. This interest of community groups has been greatly appreciated not only because of the specific contributions made but because it has demonstrated a community awareness of the services rendered by the hospital.

A staff of both full time and part time phy-

sicians participate in caring for patients, the training of residents in Pediatrics, and in the investigation of disease in childhood.

Research programs in the study of disturbances of water and electrolyte physiology during disease, of lead poisoning, of tuberculosis, of rheumatic fever and kidney disease, of poliomyelitis and of calcium and phosphorus metabolism are being conducted on the Pediatric Service. A few of the publications reporting such research are listed below which indicate the scope of the work being done.

1. Hypernatremic Dehydration, Laurence Finberg, and Harold E. Harrison, Pediatrics, In Press.
2. The Treatment of Diarrhea in Infancy, Harold E. Harrison, Pediatric Clinics of North America 1, 335, 1954.
3. Disturbances of Ionic Equilibrium of Intracellular and Extracellular Electrolytes in Patients with Tuberculous Meningitis, Harold E. Harrison, Laurence Finberg, and Evelyn Fleishman. J. Clin. Invest. 3, 300, 1952.
4. Factors Affecting Prognosis of Tuberculous Meningitis Treated with Streptomycin. Laurence Finberg, Pediatrics. 8, 768, 1951.
5. Poliomyelitis Infection in Households, Frequency of Viremia and Specific Antibody Response. David Bodian and Ralph S. Paffenberger, Jr. with the assistance of V. O. Wilson, L. A. Weed, T. B. Magath, L. A. Bine, H. E. Harrison, and L. Finberg. Am. J. Hygiene, 60, 83, 1954.
6. Treatment of Lead Encephalopathy with BAL. Julius M. Ennis and Harold E. Harrison, Pediatrics, 5, 833, 1950.
7. Amino-aciduria, Hypophosphatemia and Rickets in Lead Poisoning. J. Julian Chisolm, Jr. et al. Am. J. Dis. Child. 89, 159, 1955.
8. Mechanisms of Action of Vitamin D. Presidential Address—Soc. for Ped. Research, May 5, 1954. Pediatrics 14, 285, 1954.

Baltimore City Hospitals
Baltimore 24, Maryland

X-RAY DEPARTMENT

JOHN DeCARLO, M.D.*

William Conrad Roentgen discovered x-rays in 1895. The first x-ray equipment at Baltimore City Hospitals was obtained in 1919. This original installation was made in the building which is now referred to as the Chronic Building. The equipment was located in Ward A.

The Department of Roentgenology was considered a subdivision of the Department of Medicine until 1935 when the Medical Advisory Board of the Baltimore City Hospitals recommended the establishment of an autonomous Department of Roentgenology.

During this early period, a part time radiologist served the department bi-weekly, but the major load of fluoroscopic work and film interpretation was done by resident physicians and visiting men in the Department of Medicine.

Increased case load soon resulted in the necessity for a full time radiologist. The first full time Chief-of-Service was appointed in 1945.

In 1946, both a residency training program and the School of X-ray Technology were established.

All radiologists who have served the Baltimore City Hospitals' Department of Radiology have been American Board Certified men. The most notable was Dr. John Pierson, Professor of Radiology, Johns Hopkins University School of Medicine and an examiner of the American Board of Radiology.

* Chief, X-ray Department.

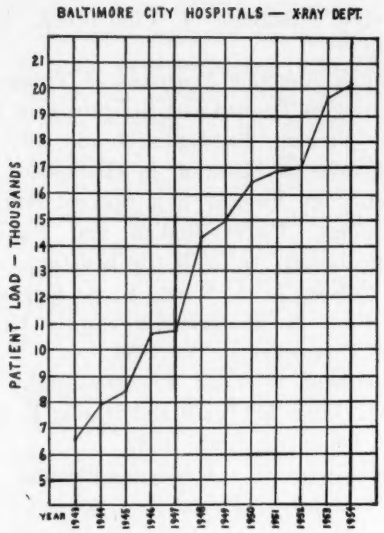

FIG. 1

In 1935, the first X-ray Department in Ward A of the Chronic Building was abandoned and a new department was established in the Acute Building (the department's present location). The x-ray therapy installation was made in 1940.

From 1946 on, the units of the early 1935 installation were gradually replaced and additional equipment was obtained to expand the x-ray service.

In 1946, the hospital obtained a photofluorographic chest unit. In 1951, a complete X-ray Department was established in the Surgical Suite; this equipment was, we believe, the first 200 M.A. installation in an Operating Room in the City of Baltimore. The Operating Room equipment makes possible any type of x-ray examination involving surgery. A large dark room with a light and dark side was built in 1953.

The Department of Radiology offers complete diagnostic x-ray service to the various divisions of the hospital. This type of service is essential to every specialty of medicine for the proper management of patients. Twenty-four hour emergency coverage is available. This means that emergency cases in the community can, at any time, receive adequate x-ray studies so that proper treatment can be started immediately.

As an additional service to the community, the department trains high school graduates in X-ray Technology. We thus supply skilled x-ray technicians to other hospitals and make it possible for the proper candidates to be trained in this special field.

The department trains physicians in x-ray diagnosis and therapy.

Baltimore City Hospitals
Baltimore 24, Maryland

A BRIEF HISTORY OF THE PATHOLOGY LABORATORY OF THE BALTIMORE CITY HOSPITALS

ABOU POLLACK, M.D.*

A recital of the history of a laboratory of pathology can best be served by sketching the accomplishments of the men who were responsible for the organization and direction of that laboratory. The names of the physicians who figured in the early years of the pathology laboratory at the Baltimore City Hospitals are now by-words in American pathology.

Dr. Opie writes that Dr. W. T. Councilman acted as pathologist to the Bay View Asylum during the period when the Johns Hopkins Med-

* Chief, Pathology Department.

ical School was being organized, and when he worked there with Dr. William Welch. In a paper with Dr. A. C. Abbott published in the American Journal of the Medical Sciences in 1885 Dr. Councilman wrote: "In the summer and autumn of 1884 an unusually good opportunity was given to the writers for the study of the pathological lesions produced by malarial fever. Bay View Asylum, the almshouse of the City of Baltimore, receives a large number of malarial cases from Harford County and other of the malarious counties of the state." Dr. Councilman has been cited by Thayer as the first in this country to confirm Laveran's discovery of the malarial parasite. "These observations were doubtless made at the Asylum." "Dr. Welch said at a dinner given in honor of Dr. Councilman: 'Dr. Councilman had no pathological material save that which he obtained outside (of the nascent Johns Hopkins Medical School). He purchased a tricycle and had occasional accidents which even got into the newspapers when the street was littered with specimens that escaped from the container attached to the tricycle.' " Dr. Councilman's name is permanently associated with the peculiar bodies found in the liver cells of patients dying of yellow fever.

The laboratory was directed by Dr. Eugene Opie from 1888 to 1893 while he was a member of the Pathology Department of the Johns Hopkins Medical School. Dr. Opie divided his time between the Hopkins Laboratory and the Baltimore City Hospitals. The same pattern was followed by his successors.

Dr. Opie was succeeded as Chief of the Department of Pathology of the Baltimore City Hospitals by a number of members of the Johns Hopkins Staff, among whom were Drs. George H. Whipple and Milton C. Winternitz. After leaving Baltimore, Dr. Whipple was in turn Dean of the Medical School of the University of California and the Founding Dean of the School of Medicine of the University of Rochester. He has since become famous as a Nobel prize winner for his work on the anemias. Dr. Winternitz, the immediate successor to Dr. Whipple, directed the pathology laboratory at the Baltimore City Hospitals up to the time of our entry into the first World War. He subsequently became Professor of Pathology and Dean at the Yale Medical School. Among those of the Johns Hopkins Staff who subsequently headed the pathology laboratory, the names of Drs. James Cash and Samuel Blackman are perhaps the best known.

Following the retirement of Dr. William MacCallum as Professor of Pathology at the Johns Hopkins Medical School, the close association between the school and the pathology laboratory of the Baltimore City Hospitals became more tenuous. Recently a closer connection between the school and the hospital has been re-established. The present Chief of the Department of Pathology of the Baltimore City Hospitals also enjoys a position on the teaching staff of the Johns Hopkins Department of Pathology.

In the early years students from the two schools of medicine in Baltimore took part of their training in the Department of Pathology at the City Hospitals. In later years, due to the growth of the staff and the abundance of material at the Johns Hopkins Medical School, it was found unnecessary to have Hopkins students supplement their training at the City Hospitals Laboratory. The students at the Medical School of the University of Maryland continued to train in Pathology as a regular part of their program at the City Hospitals. It is hoped that with the redevelopment of the larger Department of Pathology at the City Hospitals, it will once again be possible to share the excellent material available with the two schools of medicine.

The department is now housed in most modern and adequate quarters where growing facilities are available for study and experimental investigation. The activities of the de-

partment are led by a full time chief, his associate, and a visiting neuropathologist. Seeking training under this staff are a resident, four assistant residents in pathology, and an assistant resident in surgery. In addition to the careful study of the most varied autopsy and surgical material the full department participates in frequent conferences with the several clinical services. It is considered that these conferences are among the most important activities of the hospital and are essential to the training of the "Compleat Physician," whatever his specialty may be. Every encouragement and help will be given to qualified members of the department wishing to pursue clinical or experimental investigation.

Baltimore City Hospitals
Baltimore 24, Maryland

DEPARTMENT OF DENTAL AND ORAL SURGERY BALTIMORE CITY HOSPITALS 1915–1955

GLENN H. WARING, D.D.S.*

The Department of Dental and Oral Surgery is completing forty years of service to the people of Baltimore City.

In 1915, through the joint efforts of Doctor L. P. Henneberger and the Welfare Board of Bay View Hospital, this service was originated. However, until the inception of this department, these cases were the responsibility of the Medical and Surgical Services.

The beginning was a very meagre one, with the original equipment consisting of a straight back chair and one small table. This limited the service principally to extractions.

In 1916, additional appropriations were granted for purchasing new equipment, result of which made the dental service an important factor in hospital care.

During the years that followed, it became evident that there was an urgent need for expanding this department. Hence, in 1926, Doctor H. Glenn Waring was appointed to the staff.

In 1928 and 1929, full-time internships were established and in 1934 Dr. Henneberger was elected to the Medical Advisory Board, thus placing the dental service on par with the other major services of the institution.

An important stepping stone in our career came in 1940, when this service added to its responsibilities the dental care of more than one-thousand Department of Welfare children living in foster homes.

The department continued to expand. Visiting members were added to the staff, having had special training in the various branches of dentistry. Due to a prolonged illness, in 1947 Dr. Henneberger resigned and Dr. Waring became chief.

In 1946, through the kindness and generosity of the members of The Baltimore Figure Skating Club, a special fund was established, making it possible for the Department of Public Welfare children to receive orthodontic care. Also in the same year, this department was approved by The American Dental Association.

One of our major problems was the care of tuberculosis patients. It was necessary to transport the patients to and from the clinic by ambulance. Our desire was to treat these patients in the sanatorium, if possible. There was no equipment available until 1954; then, we opened the first dental clinic in Baltimore devoted

* Chief, Dental Service.

solely to the treatment of tuberculosis patients. At first, the demand for care was overwhelming. An average of over one hundred patients was seen each week and all types of dental services were performed. Currently, each new patient admitted to the sanatorium is given a thorough oral examination. A dental chart is filled in and the patient listed in categories according to his immediate needs.

In this modern era, where everything is done in a systemized way, our dental service is well established and is as indispensable in the rehabilitation of the health of the patient as in any branch of medicine. In our daily work we have added tremendously to scientific treatment in conserving dental health. Methods of treatment that were never performed ten or fifteen years ago have become routine. These include modern approaches to operative preventive dentistry; apicoectomy; pulpotomy; re-implantation; immediate prosthetic restoration and the problem of mass extractions associated with systemic diseases, etc. Several years ago the dentist hesitated to treat a diabetic, a tuberculosis patient, or even a pregnant patient, fearing possible complications following extractions or any oral surgery. Now, with the discovery of the wonder drugs and the aid of unlimited research work together with the cooperation of the physicians we can satisfactorily treat these patients. Early diagnosis of many cases of malignant growths in the oral cavity is now made by the dentist, where previously, these diagnoses were made by the physician.

This department, with five visiting staff members, two full time internes and the chief, holds the distinction of training dental graduates on post-graduate levels.

Baltimore City Hospitals and its Dental Clinic is a member of the Visitor Exchange Program which trains foreign graduates, thus indicating that the training and teaching is of the highest quality and in the latest modern trends of dentistry as approved by the American Dental Association.

The extensive training program offered is: administration of general anesthesia, working in cooperation with the surgeon in the operating room, closed and opened reduction of mandibular and maxillary fractures, radiographic examination and interpretation, carcinoma study and radon "C" therapy, audio-visual study in oral medicine, sound practical uses of elevators, immediate prosthetic restorations, and the use of nitrous oxide gas anesthesia in the practice of Pedodontia.

As a refresher course, the dental staff holds monthly seminar conferences where problem cases in dentistry are studied and solved.

In addition to the above schedule, weekly ward rounds are made in the medical and surgical divisions. Requests for consultation are received from the Pediatrics and other departments, enabling the dental staff to examine and treat both acute and chronic patients.

Although the dental staff cannot be praised too highly and the results of their efforts must not be underestimated, plans must be made to expand and widen our perspective, if dentistry is to meet the increasing needs for patients of this hospital. More than six thousand dental operations were completed in the clinic during the past twelve months.

We look forward to the future with optimism. Our plans include:

1. Having a complete dental library of our own. A collection of colored slides in oral medicine and series of x-ray films showing rare cases in dentistry.
2. A research project on:
   (a) carcinomata of the mouth
   (b) fracture treatment
   (c) dental caries
   (d) re-implantation
3. Incorporating training in the City Hospitals dental clinic as a part of a post-graduate course in oral surgery.
4. Broadening our training to include dissection of the head and neck, this to be done in the department of pathology.

Baltimore City Hospitals
Baltimore 24, Maryland

DEPARTMENT OF GYNECOLOGY—BALTIMORE CITY HOSPITALS

BEVERLEY C. COMPTON, M.D.*

Previous to February 1953 the Gynecological Department at the Baltimore City Hospitals was a sub-department of Surgery. At that time a separate department was created to coordinate with the Department of Obstetrics in order to meet the requirements of the American Board of Obstetrics and Gynecology. The Gynecological Department was to begin to function July 1, 1953. These requirements have been met and approved.

The writer was chosen as chief with two assistants from the University of Maryland and two from The Johns Hopkins University Medical Schools.

To date, an extremely active service has evolved which is rapidly increasing in activity and service to the community. In 1954, only six months after the service was started, we had 688 admissions and 644 discharges on whom 325 minor and 131 major operations were performed. There were four deaths. In the outpatient department 2160 visits were recorded. There were 227 hospital consultations. Analysis of the operative procedures shows a well rounded but conservative service in function.

The resident staff has participated in the following extra-hospital activities:

I. At the University of Maryland Hospital and Medical School.
   a. Dog Surgery—limited program.
   b. Surgical Anatomy.
   c. Course in Basic Sciences.
   d. Staff meetings and Journal Club, Gynecological Department.

II. At The Johns Hopkins Hospital and Medical School.
   a. Weekly ward rounds, Gynecological Department.
   b. Course in Gynecological Pathology.

III. Mercy Hospital.
   a. A recently developed course in Gynecological Pathology.

At the Baltimore City Hospitals ward rounds are held twice weekly, operative procedures are closely supervised, and monthly history meetings are held.

* Chief, Gynecological Service.

Baltimore City Hospitals
Baltimore 24, Maryland

ANESTHESIOLOGY DEPARTMENT

OTTO C. PHILLIPS, M.D.*

The Anesthesiology Department is the youngest department at the Baltimore City Hospitals, and it is still going through an early phase of growth, development and organization. Prior to the setting up of this department all anesthesias were given by house officers training in fields other than anesthesia, with no supervision by qualified anesthesia personnel. There was unanimous agreement that the existing situation was unsatisfactory. It was felt that the most desirable solution would be to have full time trained Anesthesiologists directing and supervising the

* Former Chief. Peter Safar, M.D. is the present Chief of the Anesthesiology Department.

department, but it was felt that men of this calibre were not available for the positions, and that if they were, the cost of obtaining them would be prohibitive. The suggestion which was accepted by the Medical Advisory Board was that a number of trained Anesthesiologists contribute on a part time basis.

The first appointment was made on August 1, 1953, and since that time the following physicians have contributed to the department: Dr. Frank Brady, Dr. Charles Hobelmann, Dr. Daniel Hope, Dr. Walter Levy, Dr. Alfred Nelson, Dr. Theodore Stacy, and Dr. Otto C. Phillips who served as first chief of the department. All of these doctors are Diplomates of the American Board of Anesthesiology or are eligible for such certification, and all of them have been engaged in the private practice of anesthesia in the City of Baltimore. Each day one member of the staff was present in the Operating Suite and supervised the entire posted schedule. Also someone was available at all times for emergencies needing consultation. The actual anesthesias were given by house officers in Surgery, Gynecology, Obstetrics, and Dentistry, by externs, and by Anesthesia Residents, the first of whom was Alejandro Gayoso of Lima, Peru, who joined the house staff on July 1, 1954.

In January, 1954, a plan for an Anesthesiology Residency was presented which called for affiliations with the Medical Schools of the University of Maryland and the Johns Hopkins University, and also with the Women's Hospital and the Union Memorial Hospital for further clinical instruction and experience during the second year of the residency. In July, 1954, the department was surveyed by Dr. Ryan, a representative of the American Medical Association, and in January, 1955, by Dr. Charles Coakley, representing the American Board of Anesthesiology.

The functions of the visiting staff in Anesthesia have been severalfold. First, it has provided supervision for the clinical anesthesia given patients. Second, in coordination with staffs of the two medical schools, it has provided instruction in anesthesia to the house staff. Third, there have been weekly meetings with the Junior Medical Students of the University of Maryland School of Medicine, in which didactic and clinical instructions and demonstrations have been provided.

On April 28, 1955 the Medical Advisory Board of the Baltimore City Hospitals approved a plan presented by Dr. Phillips calling for two full time staff physicians in the Anesthesiology Department. This plan was approved and Dr. Peter Safar was appointed as the new full time Chief of the Anesthesiology Department as of July 1, 1955. With the organizational development of the department, it is anticipated that time will be available to the staff to develop clinical and basic science research projects in addition to the aforementioned activities and functions.

Baltimore City Hospitals
Baltimore 24, Maryland

THE SECTION ON GERONTOLOGY

N. W. SHOCK, PH.D.*

Since 1900, average life expectancy has increased from fifty years to almost seventy years in the United States. As a result, the number of people over the age of sixty-five is increasing almost four times as fast as is the total population. Consequently, we are faced today with a continually growing number of older people,

* Chief, Section on Gerontology, National Heart Institute, National Institutes of Health, Bethesda, and the Baltimore City Hospitals, Baltimore, Maryland.

many of whom suffer from the chronic progressive and disabling disorders. This section of our population will continue to increase and will remain an urgent problem until enough is known about aging so that health may be maintained and older people can retain gainful employment. Recognizing the social importance of this problem and their responsibilities to the community, Baltimore City Hospitals, in collaboration with the National Institutes of Health in the U. S. Public Health Service, established in 1940, the Section on Gerontology, which is devoted to a research program on the problems of aging and the diseases of older people. From the modest beginning in 1940 with one research worker and one technician, the Section has been gradually expanded over the years to its present full time research staff of thirty people. This staff is supported by the National Institutes of Health of the Public Health Service, U. S. Department of Health, Education and Welfare, and is one of the operating units of the National Heart Institute. The staff includes medical officers who hold commissions in the Public Health Service, U. S. Department of Health, Education and Welfare, as well as physiologists, biochemists, biologists and psychologists who hold regular Civil Service appointments within the National Heart Institute. All operating costs for the research activities and purchase of research equipment are provided for in the regular budget of the Heart Institute. Laboratory space, offered by the Baltimore City Hospitals, includes seven chemical laboratories, five physiological laboratories, a fluoroscope room, an isotope laboratory, a special diet kitchen, a conference room and library, a photographic dark room, a constant temperature room and six testing rooms. The medical services for one of the wards in the Chronic Division of the Baltimore City Hospitals is provided by the physicians on the staff of the Section—all new admissions to the Infirmary Division of the Baltimore City Hospitals are examined and evaluated by the staff of the Section. Although the physicians on the staff are interested in research programs of the Section, they have responsibility for the clinical evaluation and care of patients under study and are appointed to the visiting staff of the Baltimore City Hospitals.

The research facilities, including technical assistance, laboratory space and facilities, are available to members of the house staff of the Baltimore City Hospitals who are interested in pursuing a research problem within the area of interests of the Section on Gerontology.

The overall program of the Section on Gerontology is concerned with describing the physiological, biochemical, and psychological changes that occur in people as they grow older. Aging is regarded as a process that goes on throughout the lifespan, so that observations are made on individuals from age twenty up to age ninety. These studies provide background information on aging people, free from clinical disease, as well as data on specific disease states. In order to obtain data over the entire age span, the Section on Gerontology has worked closely with all other divisions of the Hospital. In addition, many of the specialized tests, developed in the Gerontology Section, are applied in special instances to patients in other wards of the Hospital for diagnostic purposes. The research problems under study in the Section on Gerontology fall into the following major categories:

1. *Cardiovascular Studies.* Age changes in the functional capacity of the cardiovascular system include studies of the characteristics of intact blood vessels, the response of peripheral blood vessels to standardized stimuli, measurements of cardiac output, alterations in blood flow to various organs and vascular response to changes in temperature, changes in posture and exercise.

2. *Pulmonary Physiology.* Studies of changes in lung capacity, the mechanics of breathing, and the diffusion of gases across the alveolar membrane are in progress. In addition, the relationship of these measures to various clinical states is evaluated.

3. *Renal Function.* Assessments of age changes

in glomerular filtration rate, renal blood flow, and rate of maximum excretion of various substances have been made. Investigations on the mechanisms of reduced renal function, observed in elderly people, who show no clinical signs of renal impairment are in progress. For this purpose, a renal physiology laboratory, utilizing clearance techniques has been developed.

4. *Metabolism and Nutrition.* The question of age changes in basal metabolic rate has been studied and investigations relating basal metabolism to other physiological variables are in progress. Age changes in thyroid function are also being studied. The important questions of dietary and nutritional requirements of older people are being investigated, with particular reference to vitamins, minerals and proteins. For this purpose, a special metabolic balance ward, with separate kitchen for food preparation, and chemical laboratories for analysis of food, urine and stools, has been established. Age differences in the response to the administration of various steroid hormones have been described.

5. *Cellular Metabolism.* One unit of the Section on Gerontology is concerned with changes in cellular metabolism and enzyme activity in tissues with increasing age. For this purpose, a small rat colony has been established where rats, age two to two and one-half years, are being reared for these biochemical studies. In these investigations, radioactive isotopes are utilized to investigate metabolic processes.

6. *Studies in Performance.* An evaluation of the work capacity in older people has been carried out using standardized exercise procedures ranging from the simple step test to arm exercise on a specially designed ergometer and walking on a treadmill. In these studies, measurements of heart rate, respiration, blood pressure, as well as oxygen uptake and CO_2 elimination are made continuously during standardized exercise as well as during recovery. These studies are of particular importance in determining the factors which limit performance in older people. As part of this program, measurements of muscular coordination, strength and timing of action potentials are carried out. For this program, instrumentation for automatically recording gas analysis of expired air, as well as recording of action potentials from muscles and nerves, has been set up.

7. *Psychology.* The psychological aspects of aging have also been studied from the point of view of changes in perceptual capacities, as well as the organization of mental performance.

Since its inception in 1940, over 150 research papers have been published by members of the Section and house staff of the Baltimore City Hospitals.[1] Through the active support of the Hospital administration, the Department of Public Welfare of the City of Baltimore and the Public Health Service, an effective research organization has been developed. This is one of the few laboratories in the entire United States which is devoted primarily to studies of aging. The research program has benefited greatly by virtue of its close integration with the clinical work of the Hospital.

Baltimore City Hospitals
Baltimore 24, Maryland

[1] A list of reprints from the Section may be obtained on request.

Board of Medical Examiners

PHYSICIAN'S RESPONSIBILITY IN PRESCRIBING NARCOTICS

LEWIS P. GUNDRY, M.D.*

The Board of Medical Examiners of Maryland frequently receives requests from practicing physicians concerning their responsibilities in the prescribing of narcotics. There is much confusion in the minds of many physicians concerning the proper procedure to be followed in the case of drug addicts who request treatment or prescriptions for narcotics. In an attempt to clarify this situation the Board wrote recently to Mr. Irvin I. Greenfeld, District Supervisor, Bureau of Narcotics, requesting an official opinion concerning these matters. Mr. Greenfeld's reply was most helpful; it is presented herewith in condensed form.

. . . The responsibility for the proper prescribing and dispensing of narcotics, under the Harrison Narcotic Law, always rests upon the physician in charge of any given case, and a corresponding responsibility rests upon the druggist who fills a prescription to determine, *in good faith*, that the prescription was issued *IN THE COURSE OF PROFESSIONAL PRACTICE AND NOT FOR THE PURPOSE OF GRATIFYING ADDICTION*. Our Bureau is not charged with the duty of laying down any fixed rule as to the furnishing of narcotics, or the frequency of the prescriptions in any particular case. We have, however, prepared, for the guidance of registrants (physicians, druggists, etc.) an outline of procedure to be observed in prescribing and dispensing narcotic drugs. This outline is in printed booklet, . . . and is identified as "Pamphlet No. 56." . . .

. . . Page three of this "Pamphlet No. 56" relates to the *good faith* of the physician in his treatment in a given case, as well as the consensus of medical opinion with regard thereto. Physicians are expected to exercise such care in every case where narcotic dosage is indicated that the patient under treatment shall receive no quantity of narcotic drugs greater than that sufficient for bona fide *medical needs*, in order that there may be no surplus for possible diversion by the patient to illicit use.

The courts of this country have, on numerous occasions, laid down the law that the issuance of prescriptions for narcotic drugs by physicians for persons who did not require them as a medicine, is unlawful and in violation of Section 2 of the Harrison Narcotic Law. This section reads as follows:

"It shall be unlawful to sell, barter, or give away any of the aforesaid drugs except in pursuance of a written order form . . . nothing contained in this section shall apply (a) to the dispensing or distribution of any of the aforesaid drugs to a *patient* by a physician . . . in *the course of his professional practice.*" . . .

The Supreme Court has stated . . .

"If a practicing and registered physician issues an order for morphine to an habitual user thereof, the order not being issued by him in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use, is such order a physician's prescription under exceptions (b) of Section 2 (of the Harrison Narcotic Act)?"

To this question, the Supreme Court answered, "to call such an order for the use of morphine a physician's prescription would be so plain a perversion of meaning that no discussion of the subject is required. That question should be answered in the negative."

You will note that the main point at issue in connection with narcotic prescriptions is whether or not the prescriptions for narcotic drugs are bona fide prescriptions, or merely orders for narcotic drugs. If the prescriptions are not issued to persons who have a medical need for narcotic drugs, the writers thereof would be outside of the protection of the law. . . .

In another case the Supreme Court held in part as follows: . . .

* Secretary, Board of Medical Examiners of Maryland.

"Manifestly the phrases 'to a patient' and 'in the course of his professional practice only' are intended to confine the immunity of a registered physician, in dispensing the narcotic drugs mentioned in the Act, strictly within the appropriate bounds of a physician's professional practice, and not to extend it to include a sale to a dealer or a distribution intended to cater to the appetite or satisfy the craving of one addicted to the use of the drug. A 'prescription' issued for either of the latter purposes protects neither the *physician* who issues it nor the *dealer who knowingly accepts and fills it.*"

In the same case, the Supreme Court stated:

"Selling, in the criminal sense, is not confined to the parting with one's property, and under Section 332 of the Criminal Code and Section 2 of the Harrison Narcotic Act, one may take a principal part in the prohibited sale of an opium preparation by unlawfully issuing a prescription to a would-be purchaser; hence there is no necessary repugnance between prescribing and selling."

In simple language, physicians, duly qualified and registered under the Harrison Narcotic Law, who issued prescriptions for narcotics NOT IN THE COURSE OF THEIR PROFESSIONAL PRACTICE and for persons who do NOT require narcotics MEDICINALLY, are in violation of the Federal Law.

In response to inquiries made of this office by physicians with regard to treatment of persons in connection with narcotic drugs, it is and always has been our policy to advise that NO PERMISSION is ever granted for the physician, or any individual, to prescribe, dispense, or obtain narcotic drugs; that whatever action is taken by the physician is his sole responsibility; . . .

Under the Harrison Narcotic Law the responsibility for the proper dispensing of narcotic drugs is placed upon the physician, and this office has no authority whatsoever to grant permission for any person to obtain, or for a physician to prescribe or dispense, narcotics for any purpose. . . .

I might add that if any legally qualified physician should, in good faith, find that the physical condition of the patient warrants the use of narcotic drugs to allay pain and suffering incident to disease or infirmity, according to the tenets of professional practice, this office will in no way interfere with the legal right of the physician to prescribe or dispense narcotic drugs to such patient. The physician, however, is expected to exercise care, in the case mentioned, that there is not made available to the patient a quantity of narcotic drugs greater than that necessary to meet his bona fide medical needs, . . .

. . . The ambulatory treatment for the cure of drug addiction has always been disapproved by the United States Bureau of Narcotics because its observation and experience have shown that the object of the treatment is practically never achieved. The average drug addict who purports to undergo this treatment will invariably seek other sources of supply as his dosage is reduced. In view of this fact, it is our policy to suggest that the addict, or physician inquiring about a case, take advantage of treatment afforded through the facilities of the United States Public Health Service, at its hospital in Lexington, Kentucky. . . .

In addition to the Pamphlet No. 56, there is a paper entitled "The Physician and the Federal Narcotic Law," prepared by Honorable H. J. Anslinger, United States Commissioner of Narcotics. This paper, we believe, is a thorough and concise documentation of the problem. Likewise, there is an article which we believe will be helpful. It appeared in the American Medical Association Journal in 1952, entitled "What to Do With a Drug Addict." Copies of these pamphlets and papers may be obtained from the Bureau of Narcotics.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.
Journal Representative

The September meeting of the Allegany-Garrett County Medical Society was held at the William James Hotel, Oakland, Maryland. It was a combined scientific and recreation meeting.

Dr. Benedict Skitarelic, *Secretary*, Allegany-Garrett County Medical Society and Dr. E. I. Baumgartner, *Chairman*, Reception Committee.

Drs. James T. Johnson, Jr., *President*, Allegany-Garrett County Medical Society; John McClusky, Pediatrician, Children's Hospital, Pittsburgh, and A. E. Mance, *Chairman*, Scientific Program.

Dr. W. Royce Hodges, Jr., *Chairman*, Refreshments

Drs. B. Skitarelic, W. O. McLane, E. I. Baumgartner and H. L. Tolson.

Drs. H. T. Robinson, Jr., A. J. Mirkin, W. O. McLane, William A. VanOrmer and many others.

An enjoyable afternoon of golf, trap shooting, motor boating, sight seeing trips and vocal music by the Barber Shop quartet of Oakland, was arranged through the efforts of the Oakland physicians. Prizes were awarded for all events. The Golf match was tied for first honors. Doctors William A. VanOrmer and W. Royce Hodges, Jr. split honors with an even score, but since Dr. VanOrmer was ahead at the seventh hole he was awarded the prize. Dr. Leland Ransom won the Shooting match.

Sight seeing around the beautiful Deep Creek Lake and fishing included the ladies.

Dr. Hugh Myers, Phillippi, West Virginia spoke on "Early Diagnosis of Cancer of the Stomach" and Dr. John McClusky, Pediatrician at Children's Hospital in Pittsburgh, Pennsylvania discussed neonatal diseases.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

The October meeting started the new season off in fine style. Dr. Isidor Ravdin, Barton Professor of Surgery at the University of Pennsylvania and one of the country's foremost surgeons, spearheaded a symposium on "Surgical Aspects of Gallbladder Disease." He spoke at length on the complications commonly encountered in diagnosis, at operation or re-operation, and pointed up differences in technique in various parts of the country. Dr. Louis Krause presented briefly the internal medical concern with gallbladders. Dr. Alfred Blalock staunchly defended the Baltimore modus operandi. Dr. Russell Morgan ably discussed the roentgenologic side, without view box.

The speakers gave freely of their experience. The discussion lasted an hour and the question-and-answers almost another hour. There was a capacity audience whose participation and interest was lively. Officers of the Allegany-Garrett County Medical Society were guests of the City Society for this meeting.

The Woman's Auxiliary served generously of coffee, hot chocolate, cookies, and coffeecake after the meeting. Patronage of this collation has grown as our members have come to look forward to it in the two years since it started.

The Executive Board of the City Society met earlier in the week and considered progress among the various problems that have come before them. Among the newer ones was consideration whether to retain legal counsel on an annual basis or continue to pay for such services on a use basis.

The Committee on the Constitution and By-Laws suggested the policy that committees concerned with segments of the Society's activities or between the Society and the public should be regarded as *Special* committees rather than *Standing* committees. The Committee reported also that strengthening of the aspects of the constitution involving moral turpitude is in process of formulation and would be taken up with appropriate legal counsel.

The Committee Studying Nursing Education presented a formal Resolution to be sent to the Society at the next meeting. This Resolution (as qualified by the Committee) was presented and approved at the October meeting.

A Sub-Committee of the Membership Committee is preparing a brochure to explain the advantages of membership in the Baltimore City Medical Society. This outline is being carefully edited and will be completed and presented to the Board at a later meeting.

The question of having a switchboard at the Medical Chirurgical Building to handle emergency medical calls was again brought up. It had been considered several years ago. Discussion as to whether it would be better to have the Medical Society handle emergency medical calls rather than a commercial exchange seemed to be dependent upon the cost involved. Mr. Marden was asked to investigate the Washington system, and other cities if necessary, and report back about the cost and feasibility.

BALTIMORE COUNTY MEDICAL ASSOCIATION

WILLIAM A. PILLSBURY, M.D.

Journal Representative

A crab feast was held at Duffy's in August, and a large gathering made the affair a social success.

The Baltimore County Medical Association resumed its regular monthly meetings on September 21, at the Dundalk YMCA. A business session was held featuring the report of the delegates to the Ocean City meeting. Following this, Dr. Lawrence Serra, Assistant Professor of Medicine at the University of Maryland and Chief of Medicine at the

Franklin Square Hospital, gave an informative talk entitled "Untoward Effects of the Rauwolfia Drug in General Practice."

The October meeting was held in conjunction with the Maryland chapter of the Academy of General Practice on October 26, at the Sheraton Belvedere Hotel. The scientific session was as follows:

Treatment of Urinary Tract Infections. Dr. Austin I. Dodson, Richmond.

Gastro-Enterology for the G.P. Dr. John T. Howard, Baltimore.

Orthopedic Problems Encountered in General Practice. Dr. Walter A. L. Thompson, New York.

Roentgenology and the General Practitioner. Dr. Laurence F. Robbins, Boston.

The scientific session was followed by a banquet which featured an address by Mac F. Cahal, Executive Secretary, American Academy of General Practice.

CECIL COUNTY MEDICAL SOCIETY

MILFORD H. SPRECHER, M.D.

Journal Representative

Dr. Webster Brown, radiologist to the Union Hospital addressed The Cecil County Medical Society at a dinner meeting held in November at Schaffers Restaurant in Chesapeake City. Dr. R. C. Dodson presided. Dr. Brown was the second senior staff member to present a paper, Dr. W. L. Wallenweber having previously addressed the Society. At other meetings case reports and discussions were presented by Dr. George Kreis, Jr., and Dr. Klaus Heubner.

Other out of town speakers during the year were Dr. Helen Taussig and Dr. Ridgeway Trimble of Baltimore, and Dr. Lawrence Katzenstein of Wilmington, Delaware.

The calendar year for the Society will close with the December meeting, which will be entirely devoted to business.

Dr. Perry Munday transferred from Statesville, North Carolina to the local Society. He specializes E. E. N. & T. with office in Newark, Delaware.

Members made news throughout the year: Dr. Ralph Andrews took a thirty-day course (postgraduate) in cardiology, given by Dr. Samuel Levine and staff at the Peter Bent Brigham Hospital, Boston, Massachusetts. Other members attended specialized courses and meetings of the State Society and The American Academy of General Practice.

Dr. Wallace Sadowski has opened his office for practice of Surgery in Havre-de Grace.

Dr. George and Clara Kreis, Jr. added Lisa to their family on April 21, and Dr. Peter and Helen Stavrakis, a son on April 30. On October 12, Dr. and Mrs. Stavrakis received their citizenship papers.

FREDERICK COUNTY MEDICAL SOCIETY

LOUIS R. SCHOOLMAN, M.D.

Journal Representative

After the traditional two month summer lapse, the society met on September 20 at Peter Pan Inn. The speaker of the evening was Dr. Thomas McP. Brown, Professor of Medicine at George Washington Medical School. He spoke on the etiology and mechanism of rheumatoid arthritis. His talk lasting one hour, given without reference to notes, was beautifully delivered, perfectly organized and succinct. Even the surgeons were absorbed. The discussion which followed could have gone on for hours had time permitted.

Two applicants for membership were present. Dr. John Wilson, a native of England and medical graduate of the University of Lusanne, Switzerland 1931, has been in the states eight years. He opened an office for the practice of general medicine in Frederick. Dr. Frederick J. Heldrich, Jr., of Baltimore had been a summer interne here. After four years of postgraduate work in Baltimore and two years in the Army, he returned to practice pediatrics in Baltimore where he became certified with the Board and Academy of Pediatrics. But the nostalgia for the green hills of Frederick overcame him so that he is now practicing pediatrics in partnership with Dr. Powell.

Dr. and Mrs. Jesse F. Fifer are being congratulated upon the birth of their fourth daughter.

Hospital Events

The medical department had its regular monthly meeting September 30. Dr. Henry Chase gave a talk on "Hemorrhage from the Upper G.I. Tract."

The surgical department had its September meeting on the 12th. Dr. Robert Pilgram spoke on "Cholangiograms during Surgery."

The subject of the September C.P.C. was a case of Addison's Disease in a Negro. After giving the anatomical diagnosis, Dr. Furie distributed copies of the Robinson, Power and Kepler test for adrenal in-

sufficiency and discussed in some detail the chemical structure and the pharmacology of the three main steroid hormones of the adrenal cortex.

A case of Gaucher's disease cured by splenectomy was presented at the October C.P.C. Dr. Furie then discussed several other diseases in which similar splenomegaly occurs.

MONTGOMERY COUNTY MEDICAL SOCIETY

MAYNARD I. COHEN, M.D.

Journal Representative

The Montgomery County Medical Society and the Montgomery County Tuberculosis and Heart Association presented Dr. E. Cowles Andrus, President of the American Heart Association and Associate Professor of Medicine, Johns Hopkins University School of Medicine, at the October meeting of the Society on October 18, 1955, at Olney Inn. Doctor Andrus' talk on "Indications for Cardiac Surgery" was enthusiastically received.

A directory of community services available to cardiac patients of Montgomery County was presented to members of the Medical Society at the October meeting by Dr. Robert Bier.

Dr. George Cohen has become an active member of the Society, and Dr. Leonore Bajda, the new County Assistant Health Officer is a new member by transfer.

Dr. McCarrick was assisted by members of the Auxiliary in selling tickets at the October meeting for the Annual Dinner Dance at the Woodmont Country Club.

The Committee on Public Health and the Executive Committee of the Medical Society approved the recommendation that this year the Diabetes Detection Drive be conducted by urging the public to take urine specimens to their physicians to be examined without charge during the period November 13 to 19, 1955. Publicity along these lines was handled by Dr. Barbara Moulton through the media of newspapers, radio and posters.

Announcement was made that the Planned Parenthood Association of Montgomery County wished to have a referral list of physicians interested in doing contraceptive work for private patients, and members interested were asked to sign up at the October meeting.

Many requests for speakers to address organizations in the community have been coming into the Medical Society. Accordingly, the Committee of the Official Speakers Roster, announced its intention to mail a questionnaire to all members of the Society, giving them an opportunity to indicate their willingness to speak. The Committee asked that questionnaire cards be returned promptly.

Dr. Marvin Mones, of the Medical Advisory Committee on Poliomyelitis, after consultation with Dr. William J. Peeples, County Health Officer, presented the following recommendations to the Medical Society.

1. In accordance with the decision of the American Academy of Pediatrics and the State Health Department, the administration of the Poliomyelitis Vaccine is recommended.
2. Children between 5 and 9 years of age should be given injections one month apart. Following the first priority group the vaccine may be given to children from 1 to 10 years.
3. The recommended charge is the usual office visit, which in most cases is $5.00.
4. Each child should be given the injection by a private physician, except those who reasonably cannot afford private care. These patients should be referred to the Health Department with a note from the private physician, sanctioning the Health Department to administer the vaccine.
5. The Health Department plans to give the second injection starting October 31. The response of the Medical Society in the Spring Program was so effective that a similar effort of cooperation would be appreciated.

WASHINGTON COUNTY MEDICAL SOCIETY

ROBERT vL. CAMPBELL, M.D.

Journal Representative

Officers elected for 1956:

President: L. A. Hoffman, M.D.

Vice-President: W. H. Shealy, M.D.

Secretary-Treasurer: E. F. Poole, M.D.

Board of Censors: F. F. Lusby, M.D.; J. H. Hornbaker, M.D.; J. H. Beachley.

Delegate #1, W. T. Layman, M.D. Alternate, J. J. Dobbie, M.D.

Delegate #2, G. W. LeVan, M.D. Alternate, J. A. Moran, M.D.

Journal Representative is to be appointed by the new President.

Necrology

A. S. CHALFANT, M.D., *Chairman*

Memoir Committee

H. Whitman Newell, M.D.
1898–1955

Dr. Newell was born February 5, 1898 in Japan, of Congregational Missionary parents. He came to the United States in 1922 at the age of fifteen and graduated from Western Reserve University Medical School in 1926. He received his psychiatric training at Pennsylvania Hospital in Philadelphia and at the Institute for Child Guidance in New York.

In 1933, Dr. Ralph P. Truitt persuaded Dr. Newell to come to Baltimore to become Clinical Director of the Child Guidance Clinic operated by the Mental Hygiene Society and affiliated with the University of Maryland Medical School. Over the years, Dr. Newell had the satisfaction of seeing this Clinic become an important part of the expanding program of psychiatric instruction at the University. In 1950, it became a part of the new Psychiatric Institute, and Dr. Newell became Associate Professor of Psychiatry, the position he held at the time of his death. Since 1937, his Clinic has been a nationally approved training center for post-graduate students in child psychiatry.

During World War II, Dr. Newell served for three years with the 142nd General Hospital Unit, stationed in the Fiji Islands and in India. During his spare time he gathered source material on native customs that became the subject for subsequent papers. He has also written numerous articles for psychiatric journals in the field of child psychiatry.

Throughout his career, Dr. Newell gave unstintingly of his time and guidance to many community organizations in the field of health and welfare, notably to the Mental Hygiene Society and the Council of Social Agencies. He is past President of the Baltimore Psychoanalytic Society and of the American Orthopsychiatric Association.

Dr. Newell's friends remember him for his warm, fun-loving personality. He loved his work, and took keen personal interest in his students and patients. He will be mourned, and his memory respected by former students and colleagues in nearly every large psychiatric center in the United States. Baltimore has lost a good teacher and a fine citizen.

Arthur M. Shipley, M.D.
1878–1955

As a student at the University of Maryland Medical School, Dr. Shipley made a brilliant scholastic record. Upon graduation he served as intern and superintendent in the University Hospital. The latter position combined many features of a modern residency with important administrative hospital duties. Dr. Shipley displayed in this service marked abilities and became recognized as a young man of great promise. These promises were abundantly fulfilled in his long and successful life.

Dr. Shipley continued during his entire active career his connections with the University of Maryland Medical School and the University Hospital. At a comparatively early age he became professor of surgery and chief of the surgical service. These positions provided opportunity for the exercise and development of his gifts as a teacher and organizer. He was widely recognized as one of the outstanding teachers of clinical surgery in the whole country, with a wide knowledge of his entire subject, a sound organization of this knowledge, and a forceful and stimulating method of presentation. In addition, his administrative abilities found application, not only in the organization of his own service, but in playing a very important part in rejuvenating and modernizing the whole Medical School. In association with the late Dr. Thomas R. Boggs, he performed a similarly valuable and successful service at the Charity Hospital of the City of Baltimore, formerly known as Bay View, and now as the City Hospitals. The surgical residency at this institution is a living memorial to Dr. Shipley.

Along with these busy activities, Dr. Shipley found time to develop a large private surgical prac-

tice. He carried on this work, not only in Baltimore, but to a remarkable degree throughout the State of Maryland, traveling frequently to the smaller cities and towns for consultations and operations. This custom and his teaching position made him personally well known to a very large number of practicing physicians all over Maryland. He was also well known nationally. He belonged to practically all of the medical and surgical societies to which he might be eligible. He held offices of honor in many of them, including the presidency of the Baltimore City Medical Society, 1910 and The Medical and Chirurgical Faculty of Maryland, 1937. Also he was a member of the Council of the Faculty from 1941–1948. He belonged to a number of smaller and more intimate groups in the profession, one of which, the Eclat Club, he valued most highly. This is a club organized at the end of World War I among reserve medical officers of the U. S. Army who had served in France in the advanced zone. Dr. Shipley was eligible to this by virtue of his distinguished record as chief of the surgical service of an evacuation hospital. He added to his patriotic contributions to the national welfare by serving in World War II as regional chairman for the Procurement and Assignment Service for Physicians, Dentists, etc., in what was first known as the Third Corps Area and later as the Second Army Area.

Much could be said of Dr. Shipley's non-professional interests. He was a great reader, especially of history, with particular concentration on the Revolutionary and Civil War periods. He had a marked fondness for poetry, and just a few days before his death recited word for word and with much expression numerous of his favorites from the Victorian and Edwardian eras of English and American verse. He liked to travel, to fish, and to foregather with congenial spirits, to the medical world and to the younger men in the profession his death means the passing of a prominent figure. To those close to him, it means the loss of an admired example and of a beloved friend.

Cecil W. Vest, M.D.
1882–1955

Dr. Cecil W. Vest died suddenly without warning during a quiet evening at home on July 3, 1955. Dr. Vest was born on April 19, 1882, in Montezuma, Iowa, the son and grandson of physicians. He took his undergraduate work in Grinnell College, Iowa and his medical course in Johns Hopkins, graduating in 1908. After five years of post-graduate work in Gynecology and one year abroad with Dr. Howard A. Kelly, he began practice in Des Moines, Iowa, with his father, Dr. Willian Edward Vest, but returned to Baltimore after six months. Practice was soon interrupted by the First World War when he was mustered in as Captain, ending the military years as Surgeon-in-Chief at Fort Meade, where he was forming a unit for active service overseas when the Armistice was signed.

The following thirty-six years were spent in a very active gynecological practice in Baltimore. Dr. Vest was for years in charge of the GYN Dispensary of The Johns Hopkins Hospital and did a great deal of clinical teaching there. He was also a member of the Consulting Staff of Church Home and Hospital and Union Memorial Hospital. He was a Fellow of the American Chirurgical Society, member of the American Medical Association and two of its constituent branches, the Baltimore City and the Baltimore County Medical Societies—his connection with the latter dating from a very successful case from Sparrows Point in his early years in the hospital.

Dr. Vest took an active interest in the Sons of the American Revolution and the Historical Societies of Maryland and Iowa. He was a Mason and Deacon of the First Presbyterian Church, a member of the Board of Governors of the Egenton Home for Girls. We list these contacts and interests yet we cannot know fully the inner resources that nourished the robust cheerfulness Dr. Vest carried with him so bracing to patients and associates alike. We know how deeply attached he was to his home, his wife and the now-grown and branching family. These sources are deep and fruitful.

His roots were deep in the soil—of Iowa as well as Maryland—and he was intensely interested in their respective histories. He made many trips back to his ancestral acres in Iowa.

In recent years out early in the morning, digging in the rows of gladioli and amid his favorite dark red roses which he tended so carefully in the garden rows at Eudowood was a noteworthy sight. This strength, this cheer, this beauty, were a gift of nature in a sense, but not without cultivation. "Nihil Absque Labore."

Luther Franklin Vozel, M.D.
1904–1955

Dr. Luther Franklin Vozel died in Baltimore, August 10, 1955, following a cerebro-vascular accident. Dr. Vozel was born fifty-one years ago in Jeanette, Pennsylvania. He took his medical training in the University of Maryland, graduating in 1935. After an internship and assistant residency in the Union Memorial Hospital, he practiced Gynecology in Lancaster, Pennsylvania, where he was Chief of Gynecology in the Lancaster Hospital. He moved to Baltimore and since 1949 has been active on the Gynecological Service and Staff Committee of the Franklin Square Hospital. Dr. Vozel was Chief of the Gynecological Staff from 1950 to 1954. He was on the Staff of the Union Memorial Hospital and a Fellow of the American Chirurgical Society. He was a member of the Lions Club, the Elks and the Hopkins Club.

He is survived by his wife Mrs. Gladys M. Vozel.

ROCKEFELLER FOUNDATION GRANTS FAVOR MEDICINE

The AMA Washington Letter, No. 84-44

During the year 1954 the Rockefeller Foundation made grants of $5,102,796 for medicine and public health, out of a total of $19,107,665. In addition, out of 334 fellows active during the year, 149 were studying in the field of medicine and public health. On medical education: "The foundation's long interest in medicine continues to move toward strong support for professional education, with special attention to key institutions in countries which are struggling to bring their medical services up to the standards of modern scientific medicine." On medical research: "The principal contribution the . . . foundation is making to the investigation and control of specific diseases is its virus program . . . a broad study of insect-borne viruses capable of attacking man. . . ." Medical grants during 1954 include $400,000 to Washington University School of Medicine for research and training in skin disorders, $150,000 to the National Research Council's Committee in Problems of Sex, $121,275 to the University of Saskatchewan in Canada for studies of schizophrenia, and $275,000 to Harvard University for research and teaching of complete family medical care.

88% OF UNION WORKERS HAVE HEALTH-PENSION COVERAGE

The AMA Washington Letter, No. 84-41

At least 11,290,000 workers under collective bargaining contracts were covered by some type of health and insurance or pension plans in 1954, according to a study by the Department of Labor's Bureau of Labor Statistics.

Most popular coverage, next to life insurance, was hospitalization, which was provided to 88% of all workers employed under union contracts. Next was Surgical with 83%, accident and sickness with 73%, accidental death and dismemberment 54% and medical benefits 47%.

The BLS report showed that new benefits were being introduced into the agreements regularly, particularly allowances for diagnostic and laboratory services, emergency accident care, and medical care in the home and physician's office. Management rather than labor generally assumes the cost of new benefits as they are added. More and more contracts are offering protection to retired workers and workers' dependents. A breakdown indicates that half the workers share in the cost of dependents' coverage, the employer pays the entire bill for 38%, and about 12% carry the entire cost of protection for their dependents.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

LIBRARY CHATTER

MARY EMILY BERGE

At this joyous holiday season when everyone is, theoretically at least, filled with a spirit of good will and benevolence, we're going to get a gripe off our chests.

We on the library staff know most of the regular users of the library by name. Sometimes they are disembodied voices on the telephone, or an illegible signature to a letter, or we know the physician through his secretary or chauffeur. There is one regular borrower we are beginning to think is a myth. We've talked with his associate, his wife, and his secretary, we've seen his name on scientific papers, we send him overdue notices frequently, but even the staff member who has been here longest has never laid eyes on him. If he ever should walk in, however, we'd know at once where his interests lie!

Not so long ago a physician came in whom we didn't know, didn't know his name, knew nothing about him. We helped him to find the material he wanted and when he said,

"May I take these out?"

We asked, "Are you a member of the Faculty?"

"Well," he replied, "I've been paying dues for ten years but this is the first time I've used the library and gotten my money's worth."

We suppressed a desire to say, "That's your own fault," but it made us stop and think.

According to the survey made by a committee appointed by the Council a year ago, $5.27 is the amount of your membership dues that goes to the support of the library. This particular physician borrowed four bound journals and a book. We happened to be particularly conscious of the cost of journals right then as it was time to renew subscriptions. So, as a matter of academic interest, we added up the cost of the four journals, $17, $14, $12 and $10, which came to $53. The cost of the book was $25, making a sum of $78.

We disregarded the cost of binding which would have made the total even higher (we were too busy to stop and work it out right then), but even so, we figure he sure got his money's worth. Plus the fact that the one time he needed the library in ten years, it was here and the books were available. Figure it out for yourself, does it make you stop and think?

Happy New Year from everyone on the Library Staff!

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Dental Survey in Baltimore Public Schools Reveals Substantial Need for Fillings

A survey of 2,520 six, eight and ten-year-old children in twenty-one public elementary schools recently completed by Dr. H. Berton McCauley, Director of the Bureau of Dental Care, and Mr. Todd M. Frazier, Director of the Bureau of Biostatistics, disclosed that half of the 840 six-year-old pupils had decay in their permanent teeth. With only five or six permanent teeth present, two or three were decayed in each affected child. At age ten, about 98 per cent of an equal number of children had tooth decay, with four or five permanent teeth per child affected. Girls had somewhat more teeth decayed than boys but practically no difference was observed between white and colored pupils or between children in high and low economic levels of the population. Children with clean teeth averaged two less teeth decayed than children with grossly unhygienic mouths.

A substantial need for fillings at all ages was observed, even among children of the relatively well-to-do. Nevertheless, there was little evidence of dental care of any kind in six-year-old pupils beyond that supplied or instigated directly by the Health Department's school dental program. Older children, especially in higher income families, received some attention, girls more than boys. However, only 60 per cent of the dental care requirements of ten-year-old girls in the higher income status were met. The needs of colored children remained high regardless of age or sex.

In years to come the prevalence of tooth decay and the necessity for dental treatment observed in this survey should be greatly reduced, but not eliminated, by fluoridation of the water supply. Consequently, it is essential to the dental health of the community that parents in every walk of life and in every level of society recognize the need of children for the services of a dentist early in life, that they teach their children to keep their teeth and mouths clean, and provide them with foods that promote health and not overindulge the appetite for sweets.

Huntington Williams, M.D.

Commissioner of Health

COUNCIL ON NATIONAL DEFENSE HEARS GOVERNMENT OFFICIALS

The AMA Washington Letter, No. 84-44

A dozen government officials appeared before the AMA's Council on National Defense this week at its meeting in Washington, giving the council first-hand the administration's policy on current national defense problems. Officials included Dr. Frank B. Berry, Assistant Defense Secretary for health and medical affairs and members of his staff; Major General Lewis B. Hershey, director of National Selective Service; the Surgeons General of Army, Navy and Air Force; Arthur S. Flemming, director of the Office of Defense Mobilization; and Surgeon General Leonard S. Scheele of Public Health Service. Also appearing before the council was Dr. William B. Walsh of the National Medical Veterans Society.

The council discussed reports on medical care of military dependents, greater incentive for military medical careers, the possibility of restricting military call ups to two periods (July and January), the staffing of medical departments, the possibility of utilizing more civilian physicians on part-or-full time basis in military facilities, and military status for Public Health Service.

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, October 28–November 24, 1955

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	27	—	1	—	41	—	24	2	—	—	4	—	—	—	23	—	4	—	6
Anne Arundel	2	—	—	—	1	—	8	1	1	—	—	—	—	—	9	—	3	—	2
Howard	—	—	—	—	—	—	1	—	—	—	—	—	—	—	4	1	—	—	1
Harford	1	—	1	—	—	—	1	1	—	—	—	—	—	—	2	—	—	—	—
Carroll	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	6
Frederick	2	—	1	6	4	1	2	—	—	—	—	—	—	3	2	—	1	t-1	1
Washington	—	—	—	—	36	—	—	1	—	—	—	—	—	4	—	—	2	—	—
Allegany	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	6	—	1
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Montgomery	1	—	—	5	—	—	4	3	—	—	6	—	—	—	9	—	4	—	1
Prince George's	11	—	2	1	—	—	2	4	2	—	2	—	—	—	13	1	2	—	5
Calvert	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
Charles	4	—	—	—	—	—	1	—	—	—	2	—	—	—	—	—	—	—	—
Saint Mary's	4	—	—	3	—	—	1	—	—	—	—	—	—	—	3	—	—	—	1
Cecil	—	—	—	—	—	—	—	—	—	—	—	—	—	7	—	—	—	—	—
Kent	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	2	—	—
Caroline	—	—	—	—	—	—	—	—	—	—	—	—	—	2	1	—	1	—	—
Talbot	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	2
Dorchester	1	—	—	—	—	—	—	—	—	—	—	—	—	3	2	—	1	—	—
Wicomico	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	1	7	—	—
Worcester	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Total Counties	53	0	5	15	82	1	44	12	4	0	14	0	0	19	76	3	36		28
Baltimore City	17	0	6	5	54	1	37	3	1	0	12	0	0	2	76	13	478		17
State																			
Oct. 28–Nov. 24, '55	70	0	11	20	136	2	81	15	5	0	26	0	0	21	152	16	514		45
Same period 1954	84	6	3	37	20	4	70	13	8	0	58	0	0	78	120	10	490		54
5-year median	118	2	2	—	68	2	55	45		0	59	2	0	49	167	20	600		38
Cumulative totals																			
State																			
Year 1955 to date	2180	12	476	333	1657	28	1604	161	104	22	2243	19	0	352	1826	186	6642		560
Same period 1954	3107	18	301	761	11389	31	2828	145	92	22	1386	17	6	839	1950	153	6953		480
5-year median	3195	22	622	—	5415	54	2145	367		40	1231	27	30	612	2260	240	6947		522

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Blue Cross - Blue Shield

BLUE CROSS IS REASONABLE

PAUL D. CARRE*

When we say that ninety-four cents out of every subscription dollar goes to provide hospital care benefits, we simply testify that the Blue Cross dollar is hard at work. That's a tremendous return on any insurance dollar. And when we multiply it out, we find that total benefits paid were $12.8 million in the year 1954, and already $12.4 million in the first ten months of 1955.

There is no question that Blue Cross membership, dollarwise, is reasonable. But the financial reports and statistical summaries, important as they are, do not tell the whole story. They do not completely justify the widespread acceptance Blue Cross has today, or why this non-profit, community program has endured so long and so well. The answer, at least in part, lies in the *reasonable* approach to subscribers in terms of services—no less important really than the actual hospital benefits provided.

Though necessarily guided by basic insurance principles, Blue Cross does many things which are not considered sound insurance practice, but which nevertheless are good for the community and which reflect a reasonable approach to the community health problem. These things, aside from dollars charged and the dollars paid out, set Blue Cross apart.

For example, membership is basically voluntary without the requirement of management participation in cost which is characteristic of most commercial health insurance. Although many companies do now share in the Blue Cross subscription cost for their employees, our membership is still largely on a voluntary basis, available to any employed group that meets our enrollment requirements. And these requirements themselves reflect the community nature of Blue Cross—groups as small as five persons may enroll and only a 50% participation is needed for the larger groups. And members in any group, large and small, pay the same subscription rates for the same benefits.

We like to call our subscription rates community rates, as opposed to the experience rates used by commercial insurers. And therein lies a long-debated issue, too complex to discuss here. But therein also lies a fundamental principle of Blue Cross—charging a single rate to all persons in the community so that the risk is spread over the whole community. Obviously, some groups use more hospital care than others—type of occupation, average age, and sex distribution all make a tremendous difference, and are reflected in insurance rates to individual groups. They are all averaged out in the Blue Cross community rate.

Another factor, tied to dollars, is the Blue Cross policy of no commissions, no agent fees, no bonuses. All employees, from the office boy to the director—and including the sales force—are paid a salary. Health insurance today is competitive, and in a competitive field, vigorous selling is essential. Accepted business practice would seem to call for some financial incentive for the sales force at least, that is, commissions, fees or bonuses. Yet Blue Cross now has some 933,000 subscribers in Maryland who have memberships in groups which salaried representatives have secured without such dollar incentives. Blue Cross has always stuck to its basic principles and will continue to, resulting in tremendous savings to the community. Overall administrative costs, including sales, billing and claims-handling, now require only six cents out of each subscription dollar, a figure seldom if ever matched anywhere in the entire insurance field.

Too often, an employee loses his health protection when he needs it most—when he leaves his job because of layoff, change of job, or retirement. This means that his family loses, too—if the insurer had provided coverage for his dependents in the first place. Under Blue Cross, the employee's protection—

* Public Relations Officer, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

for himself and his family—is his to keep when he leaves his place of employment. And he may keep it as long as he likes, take it with him wherever he goes—to Podunk on a new job, or to Florida to retire.

These are just a few examples of the reasonable approach taken by Blue Cross which benefits all subscribers in so many ways and sets Blue Cross apart. There are many more, some equally important to these mentioned. They all combine in a unique way to put Blue Cross as close to every human situation as an organization and a contract can be. Blue Cross is not perfect—much remains to be done in the way of both services and benefits, in meeting the changing social and economic pattern of community health care—but Blue Cross has laid a good foundation on which to build.

PREMARITAL BLOOD TEST

Maryland State Department of Health Monthly *Bulletin*, October 1955

Among the states on the eastern seaboard, only Maryland, the District of Columbia, and South Carolina do not require the premarital blood test. In the rest of the country, states which do not have the blood test law include Mississippi, Minnesota, New Mexico, Arizona, Nevada, and Washington—nine in all of the United States.

Legislation to require the premarital blood test in Maryland has been introduced repeatedly into the Legislature, but these bills have firmly been opposed by the State and City Health Departments, their venereal disease experts and those of the universities in the State, and by the Maryland Medical and Chirurgical Faculty. An excellent statement entitled "Why Is a Premarital Blood Test Law Unsound Legislation?" prepared by Dr. Nels A. Nelson, was published in the *Health News* of the Baltimore City Health Department for May, 1947.

In brief, the major reasons underlying the opposition to the compulsory blood tests are:

(a) The premarital blood test finds only a relatively small number of infectious cases of syphilis which are not already known to health authorities from clinic activities and reports of physicians. Moreover, these small numbers of successes are steadily declining. For example, recent data from New York State, furnished through the courtesy of Dr. Evan W. Thomas, venereal disease consultant, indicate that the new infectious ("early") cases of syphilis (i.e., those capable of transmitting the disease to others) as revealed by the premarital blood test in upstate New York was, in 1946, about 2.2 per 10,000 persons examined. By 1954, only one new infectious case of syphilis was found per 10,000 persons examined!

(b) It follows from the foregoing that the premarital examination system is extremely expensive, Condit and Brewer[1] reported that in California, the cost per unknown case discovered, infectious and non-infectious as revealed by the premarital blood test, was $2,741 per case in 1951, and that this cost has been increasing rapidly. The New York State data cited above indicate that in 1954 the cost per infectious case discovered is many times the California figure—about $30,000 per infectious new case found, assuming only the usual hospital laboratory charge of $3 for the blood test and adding no loading for the physician's fee, which usually must be paid.

(c) It has repeatedly been shown[2] that "false positives" result by the usual tests on the blood of many nonsyphilitics. Such false positives can be caused by many fevers, including malarias, some pneumonias, recent vaccinations, and other causes. In some such groups, more than 10 per cent of the blood sera have shown false positives, calling for more conclusive retests and highly skilled interpretations.

1. Philip K. Condit and A. Frank Brewer. Premarital examination laws—are they worthwhile? California experience with 2,000,000 examinations, Amer. Jour. of Pub. Health, **43** (1953): 880–887.
2. J. E. Moore and C. F. Mohr, Jour. Amer. Med. Assn., October 4, 1952, 467–473.

Woman's Auxiliary Medical and Chirurgical Faculty

MRS. ALBERT E. GOLDSTEIN, *Auxiliary Editor*

THE WOMAN'S AUXILIARY TO THE BALTIMORE COUNTY MEDICAL ASSOCIATION*

MRS. LOUIS DALMAU†

The Woman's Auxiliary to the Baltimore County Medical Association is now completing its sixth year. As we look back, we know it is the strong foundation built in 1950 and maintained through the ensuing years that has enabled us to report the progress we have made in 1955.

Our primary aim this year has been to increase attendance at the meetings. With this in mind, we have streamlined the business part of our program, and have made reports concise and to the point. Two executive board meetings and four regular meetings have been held during the year.

In February, the guest speaker was Mr. D. E. Zaid, who is a well-known interior decorator in Baltimore City. Members were asked to submit their own decorating problems, which Mr. Zaid very skillfully helped them to solve. This was a most enjoyable and enlightening meeting.

Our Annual Doctor's Day Dinner Dance was held in March at the Sheraton Belvedere Hotel. Each doctor was presented with a red carnation. Proceeds from this affair were used for the Nursing Scholarship Fund.

In April, the guest speaker was Mr. Loyal Calkins, Criminal Psychologist, whose topic was "The Role Punishment Plays in Juvenile Delinquency."

In June, a joint meeting with the B.C.M.A. was held at the Stafford Hotel. Dr. Louis Krause gave a most interesting talk on "Medicine and Religion." Presentation of our Sixth Annual Nursing Scholarship, to an outstanding Baltimore County Student, was made at this time. As of this date, we have four students in nursing schools and two who have graduated. There are now "Future Nurses Clubs" organized in practically all of the Baltimore County Public High Schools.

At our October meeting, Mrs. Gerald W. LeVan, President of the Woman's Auxiliary to the Medical and Chirurgical Faculty, spoke to us on "Auxiliary Work and Its Importance to the Medical Society."

Our campaign to interest women in subscribing to "Today's Health" has been carried out most effectively by our chairman.

Auxiliary members in every community participate in community projects and health drives, and the Civil Defense Casualty Clearing Stations.

We have supported our medical schools by contributing to the A.M.E.F.

Your President has been elected as a member of the Executive Committee and Board of Directors of the Baltimore County Public Health Association, representing the Woman's Auxiliary of the Baltimore County Medical Association, and has attended all executive board meetings.

It has been a pleasure and a privilege to serve as County President. I am most grateful to all of those who have helped to promote the Auxiliary program.

* This is one of a series of reports from the Component Auxiliaries.

† President, Woman's Auxiliary to the Baltimore County Medical Association.

WORLD MEDICAL GROUP EXTENDS INVITATION

L. H. BAUER, M.D.*

A new opportunity for our auxiliaries to participate in the social and humane objectives of their medical men opened recently with the announcement at the New York offices of The World Medical Association that the assistance of women in W.M.A objectives will be sought in a forthcoming membership drive of that Association's United States Committee.

* Secretary-Treasurer, The World Medical Association, United States Committee, Inc., former president of the American Medical Association.

Dr. Louis H. Bauer, former A.M.A. President and now W.M.A. Secretary General, said last week in connection with the new drive: "Heretofore we have not sought the support of Women's Auxiliaries for W.M.A. work primarily because we have, as an organization, been in the embryo stage. That the assistance of interested doctor's wives, working directly with their auxiliaries, will be invaluable to reaching W.M.A. goals, there is no question. We have recognized from the start that we needed them, and I believe now is the time to ask for their aid. Many women have felt slighted in the past because we did not include them in the program. If our new membership drives in connection with the Auxiliaries are successful, we may be able to form an Auxiliary for the United States Committee. Doctor's wives, like doctors themselves speak a universal language and have common goals."

The World Medical Association, composed of the national medical associations of fifty countries (including the A.M.A.), is supported by committees such as the United States Committee, which is the branch of the W.M.A. our Auxiliary members are invited to join.

For those few of you who have not heard of The World Medical Association, we can sum up its interests briefly:

In 1947, when it became evident that an increasing number of problems pertaining to health were being resolved by non-medical bodies at the world level, the W.M.A. was organized. Formed to represent the practicing medical and allied professions internationally, it is the only organization of its kind, and the single professional body with the recognition necessary to convey the medical viewpoint to and protect medical interests before other international organizations. Primarily, the W.M.A.'s aims are the raising of medical education standards over the world, the raising of world public health levels; the improving of industrial and occupational health programs in all countries; and the blocking of attempts to force socialized restrictions on free doctors who, from Hippocrates to Salk, never found any law outside their own consciences necessary to their fulfilling the scientific and moral obligations necessary to their calling. The W.M.A. believes in free enterprise.

The objectives of W.M.A. are fully supported by the Auxiliaries. Certainly no group of women are more concerned about and interested in improved health for all people and in the promotion of a harmonious and peaceful world. They can be more effective in such an aim than politicians who are apt to endeavor to solve everything by legislation and government controls.

The W.M.A.'s new membership drive is, of course, intended to include doctors themselves, and all our Maryland State Auxiliary members are invited and urged to extend an equal invitation to their husbands if they are not already in the United States Committee. It is an interesting fact that The World Medical Association, which comprises almost all the medical associations of the free world directly or indirectly, is the one medical organization in which doctors and doctors' wives have equal status in Association matters as individual members of the United States Committee. (Hooray for W.M.A.)

For all you interested wives we are including a United States Committee application blank on this page.

Dr. Louis H. Bauer, Secretary-Treasurer
U. S. Committee, Inc., The World Medical Association
345 East 46th Street, New York 17, New York

I desire to become an individual member of The World Medical Association, United States Committee, Inc., and enclose a check.

1 year membership..... $10.00

Signature.....

Address.....

.....

(Contributions are deductible for income tax purposes.)
Make checks payable to the U. S. Committee, W. M. A.

Coming Meetings

BALTIMORE CITY MEDICAL SOCIETY

GRANT E. WARD, M.D., *President* JOHN N. CLASSEN, M.D., *Secretary*

Friday, January 6, 1956, 8:30 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Symposium on Polio Vaccination. EDWARD DAVENS, M.D., *Moderator*, Chief, Bureau of Preventive Medicine, Maryland State Department of Health.

Discussants: LAURENCE FINBERG, M.D., Assistant Chief, Department of Pediatrics, Baltimore City Hospitals, DAVID BODIAN, M.D., Associate Professor of Epidemiology, The Johns Hopkins University, ALEXANDER J. SCHAFFER, M.D., Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine.

OTOLARYNGOLOGICAL SECTION

WALTER E. LOCH, M.D., *Chairman* THEODORE A. SCHWARTZ, M.D., *Secretary*

Tuesday, January 10, 1956

Johns Hopkins Club, Homewood Campus, Dinner Meeting 6:30 p.m.

The Lump in the Neck. JOHN J. CONLEY, M.D., New York City.

Discussion to be opened by Dr. Grant E. Ward.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

RICHARD W. TELINDE, M.D., *Chairman* BEVERLEY C. COMPTON, *Secretary*

Thursday, January 19, 1956, 5:00 to 6:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

GENERAL PRACTICE SECTION*

KENNETH KRULEVITZ, M.D., *Chairman* JOSEPH S. BLUM, M.D., *Secretary*

Thursday, January 19, 1956, 9:30 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Common Pitfalls in Cardiac Diagnosis and Treatment. SIDNEY SCHERLIS, M.D.

MATERNAL MORTALITY COMMITTEE

HUNTINGTON WILLIAMS, M.D., *Chairman* GEORGE H. DAVIS, M.D., *Secretary*

Thursday, January 26, 1956, 3:30 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and Baltimore City Health Department.

* Section of the Baltimore City Medical Society.

THERAPEUTIC BILE

for patients with liver and gallbladder disorders

confirmed in the laboratory

In the isolated perfused liver (rat), *hydrocholeresis* with *Decholin Sodium* increases bile flow from 50 to 200 per cent—with no increase in bile solids.

(A) *Hydro*choleresis: Bile capillaries (rabbit liver) are filled with dilute bile 15 minutes after i.v. injection of sodium dehydrocholate.
(B) Untreated control.

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Decholin® — Decholin Sodium®

Decholin Tablets (dehydrocholic acid, *Ames*) 3¾ gr. (0.25 Gm.). *Decholin Sodium* (sodium dehydrocholate, *Ames*) 20% aqueous solution; ampuls of 3 cc., 5 cc. and 10 cc.

(1) Clara, M.: Med. Monatsschr. 7:356, 1953. (2) Brauer, R. W., and Pessotti, R. L.: Science *115*:142, 1952. (3) Schwimmer, D.; Boyd, L. J., and Rubin, S. H.: Bull. New York M. Coll. *16*:102, 1953.

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The generous protein intake of babies fed milk and carbohydrate formulas such as Lactum promotes the formation of muscle mass. It also provides for good tissue turgor and excellent motor development.[1]

(1) Jeans, P. C., in A. M. A. Handbook of Nutrition, ed. 2, Philadelphia, Blakiston, 1951, pp. 275-278.

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